HEALTH CARE POLICIES IN CENTRAL AND EASTERN EUROPEAN COUNTRIES AND EUROPEAN INTEGRATION: COMPETING APPROACHES

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL OF SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

SAFİNAZ GÜZEL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF MASTER OF SCIENCE
IN THE PROGRAM OF
EUROPEAN STUDIES

DECEMBER 2009

Approval of the Graduate School of Social Sciences

____

Prof. Dr. Sencer Ayata
Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Master of Science.

____

Assist. Prof. Dr. Galip Yalman
Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of Science.

____

Assist. Prof. Dr. Galip Yalman
Supervisor

Examining Committee Members

Assist. Prof. Dr. H. Tolga Bölükbaşı (Bilkent Uni., Pol. Sci) ________________

Assist. Prof. Dr. Galip Yalman (METU, ADM) ________________

Assist. Prof. Dr. Dimitris Tsarouhas (Bilkent Uni., IR) ________________

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

First Name, Last Name: Safinaz, Güzel

Signature:

ABSTRACT

HEALTH CARE POLICIES IN CENTRAL AND EASTERN EUROPEAN COUNTRIES AND EUROPEAN INTEGRATION: COMPETING APPROACHES

Güzel, Safinaz

M.S. In The Program of European Studies

Supervisor: Assist. Prof. Dr. Galip Yalman

December 2009, 142 pages

The objective of this thesis is to examine the nature of health care system change in the Czech Republic and Hungary after the collapse of communism. In order to do so, the thesis focuses mainly on Europeanization and New Institutionalism as competing approaches in explaining domestic changes in Central and Eastern European Countries. While doing so, first this study tries to explore whether Europeanization is one of the main determinants in the transition process of the health care systems of the Czech Republic and Hungary and discusses the EU-level policies, laws and regulations related to the health care sector. Second, the study looks through the historical legacy and path dependency theories as branches of the New Institutionalist approaches to investigate the transition of the health care systems of case countries. The review of the related literature and empirical case studies exhibit that the transformation process of the health care systems of the Czech Republic and Hungary were possibly affected by many factors and it would be misleading to attribute all consequences to only one determinant. In this respect, the main argument is that the Europeanization effect is weak compared to the New Institutionalism approach in explaining the transition process of health care systems of Hungary and the Czech Republic; however, there are strong opportunities for EU institutions to shape the future contours

of health care systems and public health programs in Hungary and the Czech Republic.

Key Words: Health care reform, Europeanization, Historical Legacy, the Czech Republic, Hungary.

ÖZ

MERKEZİ VE DOĞU AVRUPA ÜLKELERİNDE SAĞLIK POLİTİKALARI VE AVRUPA ENTEGRASYONU: ALTERNATİF YAKLAŞIMLAR

Güzel, Safinaz

Yüksek Lisans, Avrupa Çalışmaları

Danışman: Yard. Doç. Dr. Galip Yalman

Aralık 2009, 142 sayfa

Tezin amacı; komünizm sisteminin çöküşünden sonraki Çek Cumhuriyeti ve Macaristan sağlık hizmetleri sistemlerinin doğasındaki değişimleri incelemektir. Bu amaca yönelik olarak tez, Çek Cumhuriyeti ve Macaristan sağlık hizmetleri sistemlerindeki dönüşüm sürecini açıklamak üzere iki alternatif yaklaşım olan Avrupalılaşma ve Yeni Kurumsalcılık üzerine odaklanmaktadır. Bunu yaparken öncelikle, Avrupalılaşma kavramının bu ülkelerdeki sağlık sistemlerinin dönüşüm sürecinde ana belirleyicilerden biri olup olmadığı araştırılmış ve bu kapsamda sağlık hizmetleri sistemini etkileyen AB düzeyindeki politika, kanun ve düzenlemeler tartışılmıştır. İkinci olarak söz konusu ülkelerdeki sağlık sisteminin dönüşüm süreci, Yeni Kurumsallaşma yaklaşımının alt dalları olan tarihsel miras (*historical legacy*) ve izlek bağımlılığı (*path dependence*) açısından incelenmiştir. Konuyla ilgili literatür taraması ve ülkelerle ilgili vaka çalışmaları, Çek Cumhuriyeti ve Macaristan sağlık sistemlerindeki dönüşüm sürecinin pek çok faktörden etkilenmiş olabileceğini ve tüm değişim süreçlerinin tek bir belirleyiciye bağlanmasının doğru olmayacağını ortaya koymuştur. Çek Cumhuriyeti ve Macaristan sağlık hizmetleri sistemlerinin dönüşüm sürecinin açıklanmasında, Yeni Kurumsallaşma yaklaşımına kıyasla Avrupalılaşma etkisinin zayıf olduğu, ancak Avrupa kurumlarının gelecekte bu ülkelerdeki sağlık hizmetleri sistemleri ve kamu sağlığı programları üzerinde oldukça etkili olabileceği

yönünde önemli göstergeler bulunduğu, bu tezin ana argümanını oluşturmaktadır.

Anahtar Kelimeler: Sağlık hizmetleri reformu, Avrupalılaşma, Tarihsel Miras**,** Çek Cumhuriyeti, Macaristan.

To my husband, MUSTAFA CEM…

ACKNOWLEDGEMENTS

I wish to express my deepest gratitude to my supervisor, Assist. Prof. Dr. Galip Yalman, for his guidance, advice, criticism and encouragement and insight throughout the research.

I would like to express my special thanks to thesis co-supervisor Assist. Prof. Dr. Tolga Bölükbaşı for valuable guidance, support, encouragement and patience throughout this long period of study.

Finally, I am sincerely thankful to my parents for their moral support and encouragement.

TABLE OF CONTENTS

PLAGIRISM………………………………………………………………... iii
ABSTRACT……………………………………………………………… iv
ÖZ………………………………………………………………………… vi
DEDICATION…………………………………………………………… viii
ACKNOWLEDGMENTS……………………………………………….. ix
TABLE OF CONTENTS……………………………………………….. x
LİST OF TABLES………………………………………………………. xiii
CHAPTERS……………………………………………………………...
1. INTRODUCTION 1
1.1. The Research Problem and Its Settings…………………….. 1
1.2. Methodological Issues………………………………………… 2
1.2.1. Definition of Independent and Dependent Variables.. 2
1.2.2. Case Selection…………………………………………… 3
1.2.3. Time Frame………………………………………………. 5
1.2.4. Indicators…………………………………………………. 6
1.2.5. Data Sources…………………………………………….. 6
2. COMPETING APPROACHES TO EXPLAINING DOMESTIC CHANGE IN NEW MEMBER STATES………………………………. 11
2.1. Domestic Impact of the EU: Insights From the Europeanization Literature…………………………………………….. 11
2.2. Insights From New Institutionalism Literature……………… 22
2.2.1. Varieties of New Institutionalisms in Addressing Policy Change……………………………………………………….. 23
2.2.1.1. Historical Legacy and Influence of Other Health Care Systems……………………………………………………………… 27
2.2.1.2. The State of the National Economy………………… 29
2.2.1.3. External Influence……………………………………... 29
2.2.1.4. Political Factors and Government Choices.............. 31

3. BISMARCKIAN HEALTH SYSTEMS: HISTORICAL AND INSTITUTIONAL CONTEXT ………………………………………… 32
3.1. The Historical Bases of the Social Health Insurance System ………………………………………………………………. 32
3.2. The Czech Republic …………………………………………. 35
3.3. Hungary ……………………………………………………...... 37
3.4. From Bismarck to Semashko and Again … to Bismarck …. 38
4. HEALTH CARE POLICY IN THE EUROPEAN UNION: A GLANCE FROM THE EUROPEANIZATION PERSPECTIVE ……. 40
4.1. Legal Framework ……………………………………………… 41
4.2. Public Health Policy in the EU ……………………………… 44
4.3. Internal Market Rules and Regulations Related to Health Care Systems of the Member States ………………………………... 46
4.3.1. Free Movement of Health Professionals …………….. 48
4.3.2. Free Movement of Patients …………………………… 51
4.4. Social Policy in the EU and Implications for the Health Care Policy of the Member States …………………………………… 58
5. HUNGARY: AN ANALYTICAL APPROACH TO THE TRANSITION PROCESSES OF THE HEALTH CARE SYSTEM ... 64
5.1. Rationales for Transition of Health Care System ………….. 65
5.2. The Role of the Hungarian Socialist Party in the Transition Process of Hungary …………………………………………………… 67
5.3. Transition of the Hungarian Health Care System in Stages 69
5.3.1. Establishment of the Compulsory Social Insurance Model and Decentralization in the Health Care System: 1988-1994 ……………………………………………………………….. 70
5.3.2. Cost Containment Objective in the Health Care System: 1995-2002 …………………………………………………… 76
5.3.3. Direction of Change in the Health Care System and Searching Ways for the Future: 2002 and Onwards ……………… 82
6. THE CZECH REPUBLIC: AN ANALYTICAL APPROACH TO THE TRANSITION PROCESSES OF THE HEALTH CARE SYSTEM ……………………………………………………………….. 87
6.1. Rationales of Transition of Health Care Systems of The Czech Republic ………………………………………………………… 87
6.2. The Actors in the Health Care Policy-Making Process …… 88

6.3. Transition of Health Care System of the Czech Republic in Stages 90
6.3.1. Establishment of the Compulsory Social Insurance Model and Decentralization in the Health Care System: 1988-1994.......... 90
6.3.2. Cost Containment Objective in the Health Care System:1995-2002.......... 95
6.3.3. Direction of Change in the Health Care Systems and Searching Ways for the Future: 2002 and Onwards... 99

7.CONCLUSIONS.......... 104
REFERENCES.......... 113

APPENDICES

APPENDIX A: Comparing the Health Care System Indicators of Hungary and the Czech Republic with EU Averages.......... 125

LIST OF TABLES

TABLES

Table 5. 1. Healthcare Reforms by Years in Hungary.................70

CHAPTER I

INTRODUCTION

1.1. The Research Problem and Its Settings

The health care systems of Hungary and the Czech Republic have been experiencing a transition process since the collapse of the communist regime in 1989. Examining this transition process in these countries, the main objective of this thesis is to test the Europeanization hypothesis which states briefly that the ensuing domestic changes are caused by European-level regulation in an effort to adapt to European integration. In order to do so, the thesis studies the European Union's (EU) *acquis* and policies which had a potential impact on domestic health care systems in the course of the transition processes in Hungary and the Czech Republic. It relies on the concept of 'domestic Europeanization' which is used in the academic literature to refer to the impact of EU-level policies and politics upon domestic change in the health care systems of case countries. From this perspective, the thesis addresses the following three sets of auxiliary questions to seek an answer to the first main research question: Can the transition of the health care systems of Hungary and the Czech Republic be characterized by a process of Europeanization? What are the health care policy preferences of the EU? What could be the specific impact of the EU *acquis* on member states' health care policies? What is the nature of qualitative changes that have taken place in the health care systems of the Czech Republic and Hungary?

Then the study asks a second main question: How can such a transition process be characterized? Would the implementation of the Social Health Insurance (SHI) system in the CEECs imply a process of path dependence in the transition processes of health care systems in Hungary and the Czech Republic?

The thesis will address these questions by testing the empirical validity of the Europeanization and New Institutionalism as sources of two competing hypotheses in the case of the Czech Republic and Hungary.

1.2. Methodological Issues

1.2.1. Definition of Independent and Dependent Variables

This thesis, in the light of the literature surveyed in Chapter II, defines Europeanization as the impact of the EU on domestic policy and focuses on changes in health care policy in Hungary and the Czech Republic which result from the European-level institutions and policy. In this respect, while European-level policies and regulations are taken as an independent variable, the degree to which health care systems are actually Europeanized is taken as the dependent variable. In exploring the nature of the first set of independent variables, the thesis will examine two sets of variables: First, European-level legislative efforts which affect the health care system directly or indirectly: How is governance at the supranational level structured, in terms of the relative strength of the national government, to create and administer health care policy? Which policy tools have been used to provide adaptation between national and European level governance in order to achieve major changes in the health care sector? Second, historical legacies of

health care systems in the two case studies: To what extent did health-care systems of Hungary and the Czech Republic differ from the Semashko model? How were the health care systems financed in these countries before communism?

As the dependent variable, this thesis will examine the nature of the changes in the health care systems of the specific cases. In this respect, the causes of major changes and the reform process of each health care system as well as selected health care indicators will be analyzed including the degree to which Europeanization comes into play.

1.2.2. Case Selection

In terms of case selection, Hungary and the Czech Republic have been chosen as these cases have share a lot in terms of the historical background of their health care systems while, interestingly, there are observable differences in the way they implement health care system reforms. In terms of the similarities, these are two countries coming from the Semashko model, a socialist integrated system, and moving closer to a Bismarckian model characterized by a social health insurance system. Furthermore, these cases have almost the same structure of polity, policy and politics in the area of health care provision, not only during the communist regime, but also before communist rule was imported into the region. In the Austro-Hungarian Empire, which both of these modern-day countries were once part of, the state gradually assumed an increasing role in the health sector in the areas of provision of health services for the poor, public health and health insurance. Hungary was the second country in Europe which passed an act on public health in 1876. The Czech Republic was

strongly influenced by the political tradition of the Austro-Hungarian Empire as it was a part of the Empire until 1918. As well in terms of case selection, these two countries are OECD members which makes it possible to have comparable data to assess the transition process in these countries.

Despite many similarities, there are some basic differences in how these countries implemented health care reform. Firstly, the key element of reform in both cases is the introduction of social health insurance funds as third-party payer; there are two models for the organization of these health funds. In the first model there is a single fund. In the second one there are multiple health funds competing with one another. In the case of Hungary, we see the single fund, which is national, and in the case of the Czech Republic, the system is characterized by multiple health insurance funds. Secondly, in terms of the EU funds as external resources for health, the scene is also different in these countries; while the proportion of EU funds remains at zero in the Czech Republic, in Hungary, it increased from 0,2 to 1,3 percent as an external source of health expenditure between the years of 1998 and 2001. Thirdly, differences are also conspicuous between the health expenditure trends in these countries. While in Hungary, public sources counted for 70 percent of total expenditure on health in 2003, this figure is much higher in the Czech Republic, at 90 percent during the same period with 92,7% in 1995 and decreasing only to 91% by 2003.

In addition, Hungary and the Czech Republic are among the most open economies in the world having been completely ‘multinationalized’. Foreign Direct Investment (FDI) had already reached 30.3% of GDP in 1995, compared to 14.8% in the Czech Republic. Since the beginning

of the transition to a democratic market economy at the end of the 1980s, Hungary has attracted a steady stream of foreign capital, well-balanced across the various sectors of the economy. Hungary, a country of 10 million inhabitants, can currently boast having attracted Foreign Direct Investment (FDI) of more than 60 billion Euros by the end of the 2008, which represents the highest per capita rate in the Central-Eastern European region.[1] The same applies more or less to Europeanization. EU integration has advanced very quickly in building up administrative capacity and Hungary has been qualified as 'ready for Europe' (Nunberg, 2000). Accordingly, the Czech Republic and Hungary are characterized by higher per-capita incomes, less severe economic decline and early health reforms implemented consistently throughout the country.

1.2.3. Time Frame

The thesis analyzes the transition process of the health care systems of Hungary and the Czech Republic since the latter years of the communist system. In this respect, the thesis divides the transition period of the case study health care systems into three sub-periods reflecting the main features of the reform efforts. The first sub-period involves the 1988-1994 period in which the transition process of the health care systems is characterized by decentralization and privatization efforts with main structural changes. The second sub-period focuses on the 1995-2004 period which is characterized by the

[1] Hungarian Investment and Trade Development Agency, Hungary:Business Brief, October 2009 available at:
http://www.itdh.com/engine.aspx?page=Itdh_Foreign

See also Hungarian Central Statistical Office, Hungary 2008, Budapest, 2009 available at:
http://portal.ksh.hu/pls/ksh/docs/hun/xftp/idoszaki/mo/hungary2008.pdf

cost containment efforts. This period is of special importance because the cases were then pre-accession countries to the European Union and it can be expected that EU-level policies would have had a significant effect on domestic changes. The last sub-period includes the time after 2002 in order to evaluate the most recent reform trends particularly since EU accession.

1.2.4. Indicators

Since there is a lack of certain indicators to test the Europeanization hypothesis, the issue of how to measure the decisiveness of the European factor has a qualitative measure and is restricted to case studies as with any other social research. In this context, this thesis explicates the main reform efforts during the health care systems' transition process in Hungary and the Czech Republic. In this respect, the thesis tries to explore if there is any sign of a Europeanization of the health care systems in the case countries by comparing the core health care indicators of case countries with the EU indicators and then analyzing the provision and implementation process of the health care reform in detail. In this context, looking through each reform in the selected time periods, the thesis will analyze the transition process to explore what the main drivers of the changes were and by which policy preferences domestic political actors were affected.

1.2.5. Data Sources

To address the validity of the Europeanization hypothesis, the thesis brings together data on the historical development and transition process of the health care systems of the case countries as provided in

the scholarly literature (published articles and books), and various data sources, such as the European Observatory on Health Care Systems, and the World Health Organization Regional Office for Europe as primary sources. At the same time, analysis of the health care policy in the EU and the health care reform efforts of the cases are based on published documents of the WHO, OECD health data, and the public health portal of the European Union, related articles and government reports. Additionally, most of the laws and regulations were retrieved from the European Observatory on Health Care Sytems, Health Systems in Transitions for Hungary and The Czech Republic.

1.3. The Structure of the Study

After this brief introduction, in Chapter II, the thesis reviews the Europeanization literature to explain the concept of Europeanization and its importance in the explanation of the transition process of the Central and Eastern European Countries (CEECs). In this regard, different approaches to the definition of the concept of Europeanization and significant Europeanization debates in the literature have been reviewed. This review demonstrates that most of the Europeanization debates focus on the impact of European level policies on domestic level politics and policies (see Börzel and Risse 2003; Hix and Goetz 2000; Radaelli 2000). Hence, in reviewing the literature, Vink (2002: 1) defines Europeanization as domestic change caused by European integration. During its evolution, some Europeanization debates have been developed and it would not be wrong to say that there are at least three distinctive theories related to the concept. One of them is 'domestic Europeanization,' which is used to refer to the impact of EU level policies and politics upon domestic changes. The term is used in a number of ways to describe a variety of phenomena and processes of

change. Consulting different definitions of the concept, Europeanization can be understood in a very broad sense as “the domestic change caused by European integration” (Vink, 2002: 4). Hix and Goetz (2000: 27) define the term as “a process of change in national institutional and policy practices that can be attributed to European integration.” According to another definition, Europeanization is “a process by which domestic policy areas become increasingly subject to European policymaking” (Börzel, 1999: 574). This chapter also reviews other approaches emanating from varieties of new institutionalism that have dominated the political science literature, especially since the second half of the 1990s. These approaches highlight the centrality of several domestic political economic factors as driving forces in addressing change in general and the process of transition of health care systems in CEECs in particular. These include the historical legacy of a given country and health care system, the influence of other health care systems as a negative or positive model for emulation, the state of the national economy, politics and government choices, and the influence of external states or entities.

In Chapter III, the historical and institutional context of Bismarckian health care systems will be analyzed. In this respect, the historical and social bases of a Bismarckian health care system and its relations with the health care systems of Hungary and the Czech Republic will be discussed. The objective of this review is to learn the special features and development of the Bismarckian health care system and to recognize the role of historical legacy in the transition process of the health care systems of these cases. This review shows that the social health insurance systems are widely referred to as possessing the characteristic features of a Bismarckian health care system. The German health care system is often considered to be the model for this

approach to health insurance as it was the first western European country to codify existing voluntary structures into mandatory state-supervised legislation in 1883 along Bismarckian lines. The history of social health insurance systems in Europe, however, as well as their core principle of social solidarity, begins considerably earlier than 1883 and exists in countries other than Germany. In addition, the health care systems of Hungary and the Czech Republic were strongly influenced by the political tradition of the Austro-Hungarian Empire of which they were a part until 1918. This comprised a Bismarckian system which was based on a social health insurance system.

In Chapter IV, health care policy in the European Union will be analyzed. As some authors argue, while during the construction of the EU, issues of health care were not given a place. The scope of EU law has since then expanded in areas which have some implications on health care (McKee et al. 2002; Mossialos and McKee 2002, Lear and Mossialos 2008). This chapter analyzes the EU-level policies and regulations as well as the decisions of Court of Justice in terms of their possible impacts on the health care systems of member states. In this context, the chapter focuses on internal market rules and regulations, public health, free movement of patients and health professionals as areas which have possible impacts on domestic health care policy-making processes, providing analysis from a Europeanization perspective.

Chapters V and VI are the empirical case studies whereby the focus is on transition process of the health care systems of Hungary and the Czech Republic. In analyzing the main reform efforts in their health care systems, the aim of this chapter is to identify the domestic health care policy preferences and the main drivers of the reform efforts in case

countries. In this context, the thesis will try to explore potential impact of Europeanization, if any, on the ensuing changes in the health care systems, especially in the health care policy-making processes of the Hungary and the Czech Republic.

The last chapter summarizes the overall arguments presented in the study and argues that while economic crisis is an initiating factor for the health care reforms, path dependence has a crucial importance even after half a century in the transition processes of health care systems of the cases selected. It should be noted, however, that health care issues are embedded in most of the common policies, EU legislation and ECJ judgments increasingly creating constraints on national health care systems. In this perspective, this study also suggests that there are strong opportunities for EU institutions to shape the future contours of health care systems and public health programs in Hungary and the Czech Republic.

CHAPTER II

COMPETING APPROACHES TO EXPLAINING DOMESTIC CHANGE IN NEW MEMBER STATES

The theoretical perspectives on explaining domestic change could be classified into two strands: one emphasizing the impact of the EU (i.e. the Europeanization literature) and the other, focusing on domestic political variables (i.e. insights from new institutionalism). Therefore in the first section, this chapter reviews the Europeanization literature to explain the concept and its importance in the explanation of the transition process of the CEECs. In this regard, different approaches to the definition of the concept and significant Europeanization debates in the literature have been reviewed. In the second section, this chapter examines other approaches to the transition of health care systems in the CEECs focusing on Hungary and the Czech Republic particularly. The aim of this section is to take into consideration other variables which could explain the transition process of health care systems of the cases.

2.1. Domestic Impact of the EU: Insights From the Europeanization Literature

Introduction: Explaining Domestic Change with the EU

The concept of Europeanization enjoys increasing popularity within academic circles since the late 1980s. Although there are many

definitions used for the concept and the definitions remain ambiguous, scholars refer to the concept of Europeanization 'when something in domestic political system is affected by something European' (Vink, 2002:1).

> "Most of the Europeanization debates focus on the impact of European level policies on domestic level politics and policies (see Börzel and Risse 2003; Hix and Goetz 2000; Radaelli 2000). Hence Vink briefly defines Europeanization as 'domestic change caused by European integration' (Vink, 2002: 1)."

During its evolution, some Europeanization debates have been developed and it would not be wrong to say that there are at least three distinctive theories related to the concept. One of them is 'domestic Europeanization' which is used to refer to the impact of EU level policies and politics upon domestic changes. In this context, the classic Europeanization literature focuses particularly on the domestic implementation of EU policies. According to Sverdrup, European integration can only be completed by fully implementation of European rules (Sverdrup 2007). The second one is 'normative Europeanization' which equates the term Europeanization with the political and economic transformation of East and Central Europe. The third one is discussed in the anthropological debate, and identifies the emergence of a homogeneous European culture and identity. Among these different approaches to Europeanization, normative Europeanization attracted more attention in political discourse and became a slogan in CEE as it put emphasis on democratization, opening up the economy and radical changes in foreign policy.

The term Europeanization is used in a number of ways to describe a variety of phenomena and processes of change. So, before starting to assess the domestic policy changes, the concept of Europeanization must be well clarified. The first step in clarifying Europeanization is to separate the different phenomena referred to by the term, that is, what is changing. According to Olsen (2001) what is changing can be distinguished in five possible ways. They are:

- *Europeanization as changes in external territorial boundaries*: This involves the territorial reach of a system of governance and the degree to which Europe as a continent becomes a single political space. For example, Europeanization is taking place as the European Union expands its boundaries through enlargement.

- *Europeanization as the development of institutions of governance at the European level*: This signifies center building with a collective action capacity, providing some degree of political coordination and coherence. Formal-legal institutions and a normative order based on some overarching constitutive principles, structures and practices both facilitate and constrain the ability to make and enforce binding decisions and to sanction non-compliance.

- *Europeanization as central penetration of national and sub-national systems of governance*: Europeanization here involves the division of responsibilities and powers between different levels of governance. All multilevel systems of governance need to work out a balance between unity and diversity, central

coordination and local autonomy. Europeanization, then, implies adapting national and sub-national systems of governance to a European political center and European-wide norms.

- *Europeanization as exporting forms of political organization and governance that is typical and distinct for Europe beyond the European territory*: Europeanization here concerns relations with non-European actors and institutions and how Europe finds a place in a larger world order. Europeanization, then, signifies a more positive export/import balance as non-European countries import more from Europe than vice versa and European solutions exert more influence in international fore.

- *Europeanization as a political project aiming at a unified and politically stronger Europe*: The degree to which Europe is becoming a more important political entity is related both to territorial space, center building, domestic adaptation, and how European developments impact and are impacted by systems of governance and events outside the European continent. A complication, however, is that there is not necessarily a positive correlation between the four types of Europeanization mentioned above, and between each of them and a politically stronger Europe.

After reviewing what the term ‘change’ may constitute as discussed in the literature, it would be better to review the literature about the definitions and explanations of the term Europeanization. Europeanization can be understood in a very broad sense as ‘the domestic change caused by European integration’ (Vink, 2002: 4). Hix

and Goetz (2000: 27) define the term as "a process of change in national institutional and policy practices that can be attributed to European integration." According to another definition, Europeanization is "a process by which domestic policy areas become increasingly subject to European policymaking" (Börzel, 1999: 574). Radaelli (2000: 4) argues that the concept of Europeanization refers to processes of (a) 'construction' (b) 'diffusion' and (c) 'institutionalization of formal and informal rules, procedures, policy paradigms, styles, 'ways of doing things' and 'shared beliefs and norms' which are first defined and consolidated in the making of EU decisions and then incorporated in the logic of domestic discourse, identities, political structures and public policies.

It should be clarified that 'Europeanization' should not be restricted to the adaptation to the EU only, but it should be taken as the administrative adaptation of executive governments to the negotiations system within the EU, the adaptation of interest groups and social movements to new institutional opportunity structures, and the normative consequences in terms of substantial political issues.

Europeanization is also defined as the process by which distinct structures of governance at the European level affect domestic structures and domestic politics broadly defined. Europeanization serves a dual (definitional) function. First it highlights the role of European politics and institutions as an independent variable in domestic politics. It turns the causal arrows around and asks how European integration and everyday policy-making affect domestic structures. Secondly, Europeanization refers to the processes by which domestic structures adapt to European integration. The process of Europeanization involves a continual arbitrage between national

differences, different adaptation pressures, different mediating institutions, and outcomes (Caporaso, 2007: 27).

One first element in common to the three approaches above is the emphasis on domestic change. Yet domestic change, or lack of it, provides a clear focus for the analysis of Europeanization as process. The question to address now becomes one of how does one know that change is correlated or caused by Europeanization, and not by other variables.

Conceptual Scope of Europeanization Research

Reviewing the related literature, it should be specified that Europeanization is a contested concept since it defines a variety of phenomena and process of change; there is not a decided definition of the concept (Olsen 2002; Börzel and Risse 2003; Radaelli 2003a). In the literature, there are three main approaches which try to determine conceptual scope of the Europeanization concept. The only commonality betweeen all definitions is that they are all concerned with the EU and its relations with the changes in policy, politics and institutional structures of the accession countries.

Firstly, Europeanization is generally understood as a top-down process of “institutional adaptation and the adaptation of policy and policy processes” (Featherstone, 2003:3). According to this approach Europeanization means the impact of the EU on domestic policy, politics and polity structures (Featherstone, 2003, Johnston, 2001; Börzel and Risse, 2000: 2; Radaelli 2003a). It is a top-down process

through which EU political, social and economic dynamics become an increasingly important part of domestic arrangements.

According to another point of view, Europeanization means European integration and institution building at the EU level (Risse *et al*. 2001; Graziano and Vink 2007). It is a bottom-up process through which national political, social and economic forces create new European institutions and governance structures. In this respect, some researchers prefer to pursue a 'bottom-up approach' and have added that studies on Europeanization should start at the domestic level, and then the formation of policies or institutions should be analyzed. Depending on the results, the effects of political challenges and pressures caused by the European integration at the domestic level can be determined (Börzel: 2002) In this regard it would not be wrong to say that the concept of Europeanization involves both bottom-up and top-down approaches.

Maarten and Graziano (2007)[2] summarize the main areas related to the conceptual scope of the Europeanization research. According to them, first, when assessing domestic adaptation to European regional integration, researchers are not restricted to the 'top-down' approach. Second, both direct and indirect effects of European integration should be included in the research scope and it should not be restricted to a uniform impact (harmonization or convergence), the differential impact of European integration should be included, as well. Third, the research scope should not be constrained to changing policy domains, but should allow for a wide potential domain of impact. The effects of

[2] See the Introduction part of Wink, Maarten, P., and Graziano, Paolo, Challenges of a New Research Agenda', in Paolo, Graziano and Maarten, P., Wink (eds.), Europeanization New Research Agendas, New York: Palgrave Macmillan, 2007

regional integration cannot be restricted to the effects on EU member states; it should also include the impact on the non-European Union members.

Third, there are some researchers who take Europeanization as a two-way process in which member states are not only passive recipients of pressure from the EU, but they also try to project national policy preferences upward to the EU level (Bulmer and Burch 2000).

Related to the conceptual scope of Europeanization research, some researchers indicate that the effects of Europeanization on domestic policies or outcomes can be both direct or indirect (Radaelli and Pasquier, 2007). When dealing with the effects of a specific European policy, one can evaluate its direct effect, which is the one easier. On the other hand, European integration introduces new opportunities and constrains which cause or result in political or structural changes. To clarify further, increased competition, cooperation between countries, increased 'transactions', exchange of information and mutual learning may have 'horizontal effects' on the domestic policy-making processes. Compared to the direct effect of a particular policy, to determine the magnitude of the indirect effects is more difficult.

In the Europeanization literature, there is a discussion on the conceptual scope of Europeanization research on the need to distinguish between the convergence theory and the concept of Europeanization in terms of meaning and scope. Radaelli (2003a) notes that convergence can be a consequence of European integration, but it must not be used synonymously with Europeanization, because there is a difference between the process and consequences. With respect to 'convergence theory', Coughlin notes the core notion of convergence

theory and states that as nations achieve similar levels of economic development they will become more alike in terms of many aspects of social life (Coughlin, 2001). In addition, some researchers believe Europeanization should not be restricted only to policy domains, but it also should include all the traditional levels of a political regime, such as politics, policy and policies (Radaelli, 2003a).

Operationalizing the EU's Impact

One of the very important problems in the Europeanization research is the issue of how to measure the decisiveness of the European factor. Graziano and Vink (2007: 3-22) highlight four points related to this question. The first one is about taking a broad approach to how Europe impacts domestic political systems. On this point, the direct and indirect effects of European integration should be well determined. Related to direct effect, a ministry could be re-organized according to the EU obligations, or a new EU directive could be transposed into the national legislation and its effects on the domestic structures could be assessed. Furthermore, indirect effects should also be taken into consideration. In this regard, domestic changes which are not the result of a particular top-down imposition from Brussels, such as cost containment pressures experienced by European welfare states, could also be a sign of Europeanization. It is well known that the EU uses "soft" methods to affect its members, as well.

The second problem is one of counterfactual reasoning, which is an essential methodological tool for Europeanization research. With respect to counterfactual reasoning, when explaining a domestic change in a country, one should be very careful to determine the real reason of change. In other words, it should be clarified that whether this

change takes its root from Europeanization, or any other determinant, such as globalization. During the 1990s Europeanization increasingly meant, from a public policy perspective, trying to control and respond to globalization (Graziano: 2003). As Schmidt has pointed out, 'Europeanization has acted both as a conduit for global forces and as a shield against them, opening member states up to international markets and competition at the same time that they protect them through monetary integration and the single market' (Schmidt: 1999: 172). In other words, the intensification of the political dimension of the European integration process has lead to the integration of the EU into the world economy by promoting competition and therefore the EU acted as a facilitator of globalization. At the same time, however, the European integration presses has also designed new policies such as cohesion policy and the European Employment Strategy, acting as an 'antidote to globalization' (Graziano, 2003: 173).

The third problem concerns doing more comparative and possibly quantitative work. Much of the Europeanization research, as any other social research, has been qualitative in nature and restricted to case studies or focused on comparison of a limited number of countries. Europeanization research should goes beyond this small-N and descriptive works using different research designs.

And the last one is the remaining importance of well-built description and process tracing. As it is stated in the previous section, Europeanization is a contested concept since it defines a variety of phenomena and process of change and there is no compromised definition of the concept. As Bulmer (2000) states that we need thick description to point out the critical junctures in European and national policy or institutional changes.

Methodology of Europeanization Research

On the methodology side of Europeanization, Caporaso states a three-step model of Europeanization[3] (2007). According to the model; the first step is 'European integration' which includes political activity taken at the supranational-level. At this point, domestic variations are not taken into consideration during the policy-making process at the EU level. The second step is identifying 'fit/misfit' which is related with the degree of pressure created by Europeanization.

The strength of the pressure will result from the degree of fit or misfit between the EU and the domestic structure or policy. It would be expected that more pressure will result in a more adaptational response at the EU level, however, such pressure is necessary but not a sufficient condition. As Knill (2001) argues, a high degree of mismatch is likely to provoke resistance to domestic adaptation, while mismatch is insignificant; it is unlikely to generate domestic responses. Thus, it is medium-degree mismatches that can be expected to lead to the most intensive national adaptation. The role of mediating factors would be essential for domestic change, which is the third step of the model.

To conclude, it is not necessary for Europeanization to establish a common EU level policy, and the socialization process is not an adequate condition, as well. What is necessary is the presence of an EU-system of discursive and/or strategic interaction for domestic policy change.

[3] For further information related to theory and method see Caporaso, James, 'The Three World of Regional Integration Theory', in Paolo, Graziano and Maarten, P., Wink (eds.), Europeanization New Research Agendas, New York: Palgrave Macmillan, 2007, p. 23-34

Europeanization can be approached as governance, institutionalization, and discourse. So the concept is used to evaluate the changing governance patterns in CEE countries. This review shows that there is no particular way to respond to Europeanization as reality; the ways to respond differ depending on the mediating actors and resources.

2.2. Insights From New Institutionalism Literature

In the literature on processes of transformation of health care systems in the transition countries, several domestic political economic factors are discussed as driving forces in these processes. These include the historical legacy of a given country and health care system, the influence of other health care systems as a negative or positive model for emulation, the state of the national economy, politics and government choices, and the influence of external states or entities. In discussing these factors, this chapter will briefly review the studies that emphasize these variables as they influence processes of health care reform in general and the CEEC countries in particular. In addressing the centrality of these domestic political economic variables, it is the new institutionalist literature that dominates the discussion on determinants of health care system development and reform in the discipline of political science (Immergut 1992, Hacker 2002, Oliver and Mossialos 2005). As Flockhart states, because the Europeanization literature mainly has been concerned with the impact of the EU, theorizing has also been limited to explaining domestic adaptation to European integration through the EU, hence ignoring other processes that might also be subsumed under the heading of Europeanization. Whilst new institutionalist theories may be well suited in explaining domestic adaptation to the EU and domestic impacts on the EU, these theories are less suitable once the historical and geographical scope of

Europeanization is broadened (2007: 3, 4). Although the studies reviewed below which emphasize the centrality of the above variables do not explicitly couch their explanations within the boundaries of new institutionalisms, it may be safely inferred that these variables can be seen as factors that are highlighted in this broad body of literature.

2.2.1. Varieties of New Institutionalisms in Addressing Policy Change

In general, new institutionalist scholarship on health care system reform and development tends to emphasize differences in the paths countries take (see Freeman and Moran 2000). There exist three broad strands within new institutionalism and the discussion below will summarize the contributions of each to policy reform in general and health care reform in particular.

First, historical institutionalism, or path dependency theory, is the branch of new institutionalism most frequently applied to explain outcomes of health policy debates (Oliver and Mossialos 2005, Guillén 2002). Historical institutionalists see the institutional organization of the polity and political economy as the principal factor structuring collective behavior and generating specific outcomes. For them, institutions affect individual action by altering the expectations the actor has of how other actors are going to act simultaneously or after them. Oliver and Mossialos (2005: 11) stress that "historical institutionalists all believe that institutions push policy along particular paths, where early choices and events play a crucial role in determining the subsequent development of institutions and policies". The culturalist school within this paradigm views institutions as resistant to reform because they structure the very choices about reform the individual would make. Also,

asymmetrical power relations play a crucial role in historical institutionalism (Hall and Taylor 1996).

Another branch new institutionalists use is the path dependency theory in the health policy debates. This perspective has a specific importance when analyzing the transition process of Hungary and the Czech Republic which is referred to as 'Back to Bismarck' (Marree and Groenewegen, 1997). By referring to path dependence, historical institutionalists stress "critical junctures and long-term processes". Hall and Taylor (1996: 10) explain these junctures as "moments when substantial institutional change takes place thereby creating a 'branching point' from which historical development moves onto a new path". While most of the researchers do not specify what these 'critical junctures' are, historical institutionalists generally refer to the impact of military conflict and economic crisis which deserves attention while explaining the transition in health care systems in CEECs In explaining path dependence, as Evans (2005: 293) points out,

> "…historical institutionalism emphasizes, first, the constraints imposed by particular national institutions and policy histories and, consequently, the theory posits that national governments' policy options are limited by national institutional structures and the consequences of past decisions".

Second, deviation from the set of available alternatives predetermined by former institutional choices would be unlikely because of the large institutional set-up costs (Hacker 2002) and the increases in costs from policy-switching due to positive learning and coordination effects (Rittberger 2003). Third, established interest groups benefit from existing institutional structures and the more veto points a political

system has, the more power these interest groups would have to stall change (Immergut 1992, Orloff and Skocpol 1984).

In applications to health care reform, Immergut (1992) for example, presents a theory of health care system reform that centers on veto points within political systems.[4]

New institutionalist perspectives stressing institutional stability posit that if basic institutions stay the same, then healthcare systems should stay the same barring a major exogenous shock. But in reality, we have seen major legislative changes occurring in Western Europe without the presence of these necessary "tipping points".[5] As many historical sociologists suggest,[6] path dependence goes beyond the simple definition of the theory which posits that past events and decisions determine or affect the course of later events. Instead, it "involves both tracing a given outcome back to a particular set of historical events and showing how these events are contingent…that can not be explained on the basis of prior historical conditions" (Mahoney 2000: 507). The role of the institutions which take their roots from the past "provide moral or cognitive templates for interpretation and action" (Hall and Taylor 1998: 8).

---

[4] But for many scholars, over-reliance on "critical junctures" to explain change cannot constitute a coherent theory. As Oliver and Mossialos (2005) point out, historical institutionalism has been criticized for lacking a coherent theoretical framework based on a set of commonly shared assumptions. Historical institutionalism is much better at explaining institutional stability than institutional change because the theory relies excessively on random exogenous shocks to explain institutional or policy change (Rittberger 2003).

[5] Examples include Denmark in 1973, Greece in 1983, Italy in 1978, Spain in 1986 – all moving from Social Health Insurance System to predominantly tax-funded National Health System. See Saltman and Dubois (2004: 26) for a discussion.

[6] See Somers M., R. (1998) and Tilly, C. (1988)

Second, rational choice institutionalists see politics as a series of collective action dilemmas. According to them, a firm's organizational structure is explained by reference to the way in which it minimizes transaction, production or influence costs.[7] Rational choice institutionalist perspectives are also scarce in political science because they rely on game theory to map out the objective function of government/society and equilibria. For rational choice institutionalists, structures still matter a great deal since they shape individuals, but their endogenous change explanations provide much more of an agency-oriented perspective than do exogenous change arguments (Oliver and Mossialos 2005, Rittberger 2003).

Third, sociological institutionalism started when sociologists began to challenge the distinction between rationality and culture. Sociological institutionalists define institutions much more broadly than political scientists: they include symbol systems, cognitive scripts and moral templates that provide the "frames of meaning" guiding human action. They consider action as tightly connected to interpretation: individuals and institutions are inextricably intertwined – individuals simultaneously constitute themselves as social actors and reinforce the convention to which they are adhering. Consequently, institutions often adopt a new practice not to maximize the means-ends ration, but to increase their legitimacy (Hall and Taylor, 1996:946-9). Factors that sociological institutionalists stress on in their analyses, such as policy transfer and cultural expectations, have often been overlooked because they are difficult to measure and an important challenge in this project would be

[7] For further information see Cf. Williamson, *Market and Hierarchies* (New York, Free Press, 1975), and Milgrom and Roberts*, Economics, Organization and Management*; and Paul Milgrom and John Roberts, 'Bargaining Costs, Influence Costs and the Organization of Economic Activity' in James Alt and Kenneth Shepsle (eds.), *Perspectives on Positive Political Economy* (Cambridge, Cambridge University Press, 1990) pp. 57–89.

to try to isolate and attempt to at least partially quantify these relationships.

In the context of health policy, particular institutional features of European Union integration have generated real and potential restrictions on member states. These requirements restricted public sector spending which undermined any movement to extend the coverage of publicly provided health care in those countries. It is also worth noting that it is possible that EU law will act as an increasingly powerful constraint upon government intervention in the health care systems of the EU member states; for example, EU competition law may restrict government intervention in private health care insurance markets (Mossialos and McKee 2002).

The factors identified below may constitute examples of the applications of a variety of new institutionalisms as applied to policy reform in general and health care reform processes in particular.

2.2.1.1. Historical Legacy and Influence of Other Health Care Systems

According to Marree and Groenewegen (1997), there are two main factors which affect the way health care systems developed after the collapse of communism: the historical legacy of the countries' health care system and the influence of other health care systems. The authors state that these two factors have served as points of reference in drafting health plans, generating possible solution and shaping the current health care systems. First, it is striking that "the pre-communist system serves [more] as a source of knowledge of other institutional

arrangements than those during the era of communist rule." In fact, although historical legacy matters, in reforming the health care system, it was the pre-war institutions that were taken as blueprints. Thus 'the communist period serves as a source of negative experience'. Secondly, the influence of other health care systems may be both positive and negative. Against the background of the history of the CEEC, "health care systems with a high level of state involvement, such as National Health Service type systems, may be a negative reference group, while pluralistic or social insurance systems may be a positive reference group" (Marree and Groenewegen, 1997: 3,4)

From another standpoint, however, some observers noted that communist legacy matters, too. For example, communist rules on health care policies and implementation constitute the major cause of problems in some countries. Lawson and Nemec (2003), for example, stated that in these systems of communist planning and priorities, health was not a high-priority sector. Although it has now decreased,

> "the influence of the legacy of communism and planning (…) can still be seen in the relatively low priority accorded to health in state budgets, in low pay among health workers, in the supply-constrained nature of the many services, and most obviously in the dominant role of the state, directly or indirectly, in determining supply, finance, incentives and new directions in provision" (Lawson and Nemec: 2003: 222).

2.2.1.2. The State of the National Economy

Another point of view is that changes of the health care system are not peculiar to CEECs as health care systems throughout the world are experiencing process of reform. According to Mechanic and Rochefort (1996) who study processes of convergence in health care systems around the world, the main driver of such processes has been the state of national economies in general. They argue that this is true for also the case of transformation of health care systems in CEE countries as they have been less able to sustain their previous health care systems. The former socialist countries of Europe, including Hungary and the Czech Republic had a centralized socialist health care system before the collapse of communism. With severe economic crisis and the collapse of the system, these countries have not been able to sustain their old systems, and the trend has been away from universal access financed by taxes from the budget. These countries attempted to develop market economies; their health care systems moved toward pluralistic approaches depending on payroll contributions and new market-like arrangements.

2.2.1.3. External Influence

As an another factor, the literature discusses the impact of other states or entities using a particular policy, influencing health care systems of other countries by exporting a component of a specific health care system or organization model. In this respect, the former socialist regimes of Eastern Europe countries present an excellent example to this kind of external influence on domestic health care system of a

country.[8] Numerous studies have often emphasized the crucial role played by international organizations in influencing the post-communist social policy reform process (Deacon et al. 1997; Orenstein 1998, 2005; Müller 1999, 2002, 2004; Manning 2004; Cerami 2005). International organizations, primarily the United Nations and the World Bank, are among the major lenders of conditionally-based development aid and influencing the policy direction through "*binding directives"* or through forms of "*moral suasion"* (Cerami, 2006:8). The World Bank, especially, as an organization which is dominated by Anglo-American interests, has been expanding its health care sector blueprint, with an explicit agenda of supporting market-oriented finance and delivery health care systems, which is an example of binding directives. As an example of *moral suasion* we can look to the OECD's *Economic Surveys* (McBride and Russel 2001) or to the EU policy evaluation reviews with their attempt to show governments what good policy-making is. In this context, the World Bank and the IMF, the policy discourse has primarily focused on the need for a market-oriented, financially stable and residual welfare state. The EU, on the other hand, has been influential in cognitive terms (Guillén and Álvarez 2004; Guillén and Palier 2004; Ferge and Juhász 2004; Lendvai 2004, 2005; Manning 2006), and in introduction of new social policy ideas, interests and institutions (Cerami 2006b).

In the literature, however, there are other researchers who take international organizations as important *facilitators* (Ekiert 2003; Inglot 2003, p. 242; O'Connor 2005) in the social policy reform process, stating that this is not sufficient to address them as the only causes responsible for specific outcomes (Cerami, 2006: 9).

[8] For example, in January 1994, the US Agency for International Development announced a $44 million contract to Abt. Associates, Inc., a Cambridge, Massachusetts to help institute market-based health care reforms in the former Soviet Republics, including an employment-based insurance system (Stein: 1994).

2.2.1.4. Political Factors and Government Choices

The factors which affect the transition of health care systems in the Hungary and the Czech Republic, however, cannot be limited only to these variables. It is certain that politics and government choices also deserve special attention as a variable influencing the transformation and re-organization of the health care system of a given country. As Walt (1994) specified, while societies face common pressures which shape their health care systems, these pressures filter through collective decision-making processes to produce the reimbursement, regulatory, and other health care policy decisions that shape a particular health care system.

CHAPTER III

BISMARCKIAN HEALTH SYSTEMS: HISTORICAL AND INSTITUTIONAL CONTEXT

This chapter discusses the historical and social bases of the Bismarckian Health System and its relations with the health care systems of Hungary and the Czech Republic. The objective of this review is to learn the special features and development of the Bismarckian Health System and to recognize the role of historical legacy in the transition process of the health care systems of these cases.

3.1. The Historical Bases of the Social Health Insurance System

The model of the social insurance system, established in Germany during the 1880s by Chancellor Bismarck, follows a participative pattern: People are insured because of their participation in some professional group, organization, industry or firm. Complementary schemes are put into place to cover those who do not come under any of the sector-specific schemes. The result is a multitude of funds, financed by direct contributions of both the employer and the employee.

The Social Health Insurance System (SHI) is widely known as the Bismarckian Health System since Germany is often considered to be the source of this approach to health insurance and it was the first western European country to codify existing voluntary structures into

mandatory state-supervised legislation in 1883. The history of SHI in Europe, however, as well as its core principle of social solidarity, begins considerably earlier than 1883 and exists in countries other than Germany.

The initial phase of the historical process of SHI had started in the late medieval period involving small groups of workers who created mutual assistance associations under the auspices of their craft guild. The first recorded guild funds date back to the 1300s. These funds generally covered only guild members, with overall coverage restricted to less than 5 percent of the total population. All others were dependent on charitable and/or religious organizations for care. This precedent of basing health coverage on occupation became a core tenet of the social insurance model in German-speaking countries and Sweden. In the late eighteenth century, the state began to take on an active role in the provision of health services. Two important trends helped shape the European health sector's future. One was in the Nordic Region, where district physicians in Sweden were given royal commissions contingent on their willingness to see indigent patients without payment. Similar policies were followed in the then Swedish colony of Finland, as well as in Norway. This is the first known effort by a state to provide health services to the poor. The second one was the continual effort by various newly consolidating states to break the economic power of the guilds. This culminated in one of the first acts of the French Revolution when, on 4 August 1789, guilds were abolished with the objective of creating a more liberal labour market, as well as increasing social equality. With the banning of the guilds, their health insurance function continued as independent (and politically unprotected) mutual assistance societies, thus setting the stage for the process of consolidating state legislative control that commenced in 1883. Once the guilds disappeared, there

was an extended period in which various, collective not-for-profit as well as private for-profit, attempts were made to organize the provision of health insurance. These civil society efforts produced mixed results, varying by country and by historical and/or cultural situation. There were, of course, exceptions to this new pattern. In Germany, for example, the guilds and their health insurance funds were largely maintained. Moreover, the emerging state supervisory role was presaged in Austria in its 1859 Industrial Code, and by state replacement of private philanthropy in substantial parts of the Netherlands and Belgium.

The modern era in SHI was created in 1883 by the conservative German Chancellor von Bismarck, with the fear of socialism that would engulf Germany. Worried about rising political pressure from Marxist-influenced labour unions and consumed by his desire to build a powerful German state, Bismarck seized upon the idea of retaining independent occupation-based sick funds but placing their activities under state tutelage. The resulting legislation established both the legal and social foundation for sickness funds not just for Germany but for much of western Europe as well. Indeed, Austria followed suit in 1887/8.

This period of growing state activity was characterized by rising rates of population coverage. The legislation passed during this period not only established the principle of state supervision and regulation of sick funds, but also required certain segments of the population (typically various groups of workers) to obtain coverage–hence the application of the term ‘compulsory’ (Saltman and Dubois, 2004: 22-24).

For the CEECs, the Bismarckian health insurance system is very important for two reasons. First, it has a special importance in terms of historical legacy matters since they have the roots and institutions of the system in their historical background. Second, as Marree and Groenewegen (1997) state, it serves as a source of positive experience, while centralist system with high level state involvement serves as a negative experience. Since the Beveridge system, which is based on National Health Services, is regarded as an example of a tax-financed health care services, CEECs tended to go to a Bismarckian health insurance system either because it constituted a positive experience or it was very difficult to make health expenditures from the budget. These factors explain why even after half a century the CEECs go back to a Bismarckian system, strengthening the historical legacy approach and bringing the path dependency theory into the picture.

3.2. The Czech Republic

Czech health policies were strongly influenced by the political tradition of the Austro-Hungarian Empire of which the Czech lands were a part until 1918. This comprised a Bismarckian system which was based on the social health insurance system. In 1887, compulsory accident insurance, and in the next year sickness insurance schemes, were introduced for blue-collar workers. In 1918, there was a fragmented system of social insurance in Austria-Hungary with the various schemes organized according to professional, regional or other criteria offering social security benefits and sickness insurance.

After Czechoslovakia’s independence in 1918, the Bismarckian health system inherited from the Empire was expanded and refined. In 1919, legislation was adopted that extended compulsory sickness insurance

coverage to the family members of blue-collar workers and to all wage earners, thus including agricultural workers for the first time. In 1924, landmark social insurance legislation led to the creation of the Central Social Insurance Fund, which consolidated the hitherto fragmented system of social insurance into a single institution. At the same time, the sickness funds were reclassified as health insurance funds. By 1938 more than half of the population of the Czechoslovak Republic was covered by compulsory health insurance (Bryndova et al., 2009: 14, 15). Step by step, the system of state health insurance was complemented by other forms of insurance and by the work of charities. This system continued to function, with few modifications, until 1951.

In 1948, shortly after the Second World War, substantial political changes took place in the country. The political system became a "people's democracy" and the country was governed by communist ideological principles, linked both politically and economically to the former Soviet Union. As a result, the proportion of nationalized property (including various forms of collective ownership) reached nearly 100%. This influenced many institutions, including the health care system. At that time, two possible systems of health care were considered as models. One was a national insurance system, more or less based on previous tradition; the other was the newly designed "System of unified state health care". In 1948, the first model was implemented, and health and social insurance were unified into a compulsory system of insurance for all citizens. The Central National Insurance Fund was founded, which covered all health care and sickness benefits. Insurance, amounting to 6.8% of wages, was paid entirely by the employer. Four years later, in January 1952, the centralist system of unified state health care was introduced. The State took over all health

care coverage and financed it through taxes (Rokosova and Hava, 2005: 12).

3.3. Hungary

Hungary has a long-standing tradition of health services dating back to infirmaries attached to monasteries in the eleventh century. After the early period of private medicine and church-dominated charities, the state gradually assumed an increasing role in the health sector in three areas: the provision of health services for the poor, public health and health insurance. In the fifteenth century, town physicians were employed to make services available for the poor, which was required of every county in 1752. Hospitals were separated from almshouses in 1856 and the eligible poor obtained free health care at special clinics. The first Hungarian act on public health, which was passed in 1876 (*Act XIV of 1876*), was the second of this kind in Europe. Village and district doctors as well as chief medical officers provided health services free of charge for residents with very low income. As far as health insurance is concerned, *Act XVI of 1840* legitimized voluntary self-help funds for industrial workers. In 1870 the General Fund of Sick and Disabled Workers was established. *Act XIV of 1891* required compulsory insurance for industrial workers. At the turn of the century, a national insurance fund for agricultural workers was set up, and the National Fund of Patient Care was established in 1898 to reimburse health care costs for the poor. A National Social Insurance Institute was formed in 1927, and by the 1930s approximately one third of the population was insured. Until the 1940s, health care was delivered mainly through the private sector and in some state hospitals. Insurance funds employed medical doctors and also owned health care facilities. Rural areas were

not well served despite the efforts of the Green Cross Service, staffed mainly by nurses (Gaal, 2004: 5,6).

3.4. From Bismarck to Semashko and Again … to Bismarck

The previous two sections of this chapter show that the Czech and Hungarian health care policies were strongly influenced by the political tradition of the Austro-Hungarian Empire of which they were once a part. The communist regime had been established in Hungary and the Czech Republic in 1948 and 1952 respectively. All the health insurance funds were abolished and private enterprises in the health care system (as it was in other sectors) were dismantled. This was a Soviet-style centralist system based on the Semashko model. In this system, all health care services are centrally financed through taxes and all health care facilities are publicly owned. As a main characteristic of the model, health care services were officially free for the population as a whole so as to provide equity in access to health care services. Despite considerable improvements in the health status of the population, the trend began to slow down in the late 1960s. The system was centralist and quite rigid in many respects and was not flexible to response changing circumstances. With the severe economic crisis, the Semashko model was unsustainable and there was a need for a radical health care reform in the case countries. With the collapse of the communist regime, a dramatic democratization and liberalization process which had significant affects on the health care system, was experienced in these countries. As a consequence, the institutions of the Bismarckian system were re-established in both countries with the separation of the Social Insurance Fund from the government budget and the introduction of private provision of health care services in Hungary. As parallel to the developments in Hungary, the General

Health Insurance Act and the Act on General Insurance Fund passed and private entrepreneurs were allowed in the health care sector in the Czech Republic. All these developments were seen as a shift of the health care systems of the case countries to a Social Health Insurance Model and qualified as ‘Back to Bismarck’ (Marree and Groenewegen, 1997).

CHAPTER IV

HEALTH CARE POLICY IN THE EUROPEAN UNION: A GLANCE FROM THE EUROPEANIZATION PERSPECTIVE

As some authors clarify, while during the construction of the EU, issues of health care was not given place, the scope of the EU law has expanded in areas which have some implications on health care (McKee et al. 2002; Mossialos and McKee 2002, Lear and Mossialos 2008). This chapter analyses the EU-level policies and regulations as well as the decisions of Court of Justice which have possible impacts on the health care systems of member states. In this context, the thesis focuses on internal market rules and regulations, public health, free movement of patients and health professionals as areas which have possible impacts on domestic health care policy-making processes.

The Europeanization effect could be expected on the member states since health care services to be effected by the rules of the single market. Free movement of goods will also include medical devices and technology, free movement of people includes patients and health personnel, and free movement of services will include health care providers and other activities required for health care. In this respect, an extensive legislation has been developed in the areas which cover directly the provision of health care. As a result, even there is not a direct regulation or policy on the heath policy at the EU level, it seems impossible for national government to put health care services beyond the reach of the EU.

4.1. Legal Framework

The development of EU law related to the health area can be listed in order as follows:

The Treaty of Rome had little to say about health, but free movements of goods and peoples could only be blocked on the ground of public health. The Treaty establishing the European Community stated the objectives of the EC as “accelerated rising of the standard of living” which paved the way for the *Europe against Cancer Programme* in 1986. In 1993, Article 129 of the Treaty of Maastricht stated that the Community will contribute to a high level of health protection for its citizens. This Article made provision for community action; particularly in the area of health protection as a part of the Community’s other policies. The most important implication of this development in the area of public health is that movement of goods and production can only be free if goods meet the safety requirements and the application of this action can be seen most notably against tobacco and its products which are the leading causes of premature death and disability in Europe.

The “Charter of Fundamental Rights of the European Union” agreed on in Nice on 7 December 2000, describes the right to “Health Care” by saying, “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices”.

One of the tasks of the Community is by establishing a common market and a monetary union to promote throughout the Community a harmonious, balanced and sustainable development of economic

activities, a high level of social protection, the raising of the standard of living and quality of life and social cohesion and solidarity among Member States (Art. 2 of the Treaty of Amsterdam). According to Article 3 of the EC Treaty, the European Community has a broad policy mandate for health ("…the activities of the Community shall include… a contribution to the attainment of a high level of health protection...") including specific tasks which are set out in Article 152 and other articles. An important provision is that Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care.

Based on Treaties, various bodies in the European Union developed actions relevant to health care. These actions can be divided into two groups;

- EU activities in the field of public health
- Health protection requirements in EU policies

Although it is common perception that the EU activities are limited to public health only, other EU policies with implication for health protection have potentially much greater influence on the health care services in the Member States. "Provision and organization of health care systems of Member States are directly influenced by activities related to research, training of professionals, pharmaceuticals, medical technology and social security" (Cucic, 2000:220). In this respect, although the EU has no formal legal power to enact Community health care legislation, several different policy domains influence health policy,

including principally: internal market, social affairs, public health, enterprise and economic policy (Lear and Mossialos, 2008:3). In addition, the Kohll and Decker and Smits-Peerbooms rulings of the European Court of Justice (ECJ) in 1998 and 2001 have proved that Member States health care systems, and in particular the delivery of health care, do not lie outside the jurisdiction of Community law.

After the Treaty of Maastricht was adopted in 1993, expanding community authority to contribute "towards a high level of human health protection" (Article 129, now 152), the Council recommended that the Commission address the promotion of social Europe (COM (1993) 531).

However, Member States had little political will to move health onto the European agenda. It was not until 2002 that the European Council of Ministers agreed that health care systems share common principles of solidarity, equity, and universality, but chose not to take any further concrete actions. After the health sector's exclusion from the EU Services Directive, which aims to break down barriers to cross-border trade in services between EU Member States, health and long-term care were formally added to Social Open Method of Coordination (OMC) procedures conducted by the Social Protection Committee (SPC) in 2005. A wide variety of health related lobbying groups opposed the application of the Services Directive. The opposition argued that health care services are 'unique' and should not be treated as any other commercial service; and that Member States would have difficulty managing their health care systems with the additional EU oversight. The 2008 Commission Communication on Social OMC proposes a new commitment to a social Europe that would strengthen the OMC process by setting targets, improving reporting,

communication and dissemination as well as improving mainstreaming and horizontal coordination (COM (2008) 418).

4.2. Public Health Policy in the EU

Public health gained more attention with the insertion of the Article 129 to the Treaty, and it provided a basis for programs related to health promotion, information, education and training. Lately, in the Article 152 of the Amsterdam Treaty, it is stated for the first time that Community action shall be directed towards improving public health which proves public health is gaining a higher priority at the EU level.

Although Member States retain the primary responsibility for organization and delivery of health services under Article 152 of the EC Treaty, this policy space is still shaped by Community law and policy. The Community did not have legal authority in the field of public health until 1999, when the public health article was amended and renumbered by the Treaty of Amsterdam as the current Article 152. Treaty Article 152 defines the role of the EU as complementing national policies, sets out procedures by which the EU institutions may act in the health field, and delineates the types of measures that may be enacted, but explicitly bars the use of harmonization. (Lear and Mossialos, 2008:1)

Within the public health sphere the EU has enacted legislation to ensure the quality and safety of blood, blood products and human tissues, and is considering legislative action to address the challenges of organ transplantation. The Community has also enacted legislation and public health campaigns to reduce the negative health impacts of

hazardous products such as tobacco, alcohol, and illicit drugs. Another important area of EU public health policy is the establishment of regulatory agencies to provide expert opinions and advice, collect and disseminate information, and generally support Community Institutions. Two of the most important agencies are the European Medicines Agency and the European Food Safety Agency which play integral roles in the Community's legislative authority to regulate the market authorization of pharmaceuticals, medical devices, and food (from 'farm to fork') to ensure that the products meet high levels of quality and safety for human consumption (Lear and Mossialos, 2008:2).

In 1993 the Commission presented a Communication on the Framework for Action in the Field of Public Health as an initial strategy document to develop work on public health. On this basis, eight action programs on health promotion, cancer, drug dependence, AIDS and other communicable diseases, health monitoring, rare diseases, accidents and injuries, and pollution-related diseases, were agreed. All of these have now been replaced by the new public health programme.

European Commission established the program of Community action in the field of public health (2003–2008), which forms an essential part of the European Community's health strategy, focusing on the following objectives and general measures:

- improving information and knowledge with a view to promoting public health and health care systems,

- boosting the ability to respond rapidly and coherently to health threats,

- addressing health determinants.

When we look closely to the legal basis for EU actions in the field of health care, we see that it is in the process of change. Whilst Article 129 of the Maastricht Treaty states a ‘contribution to health protection’, Article 152 of the Amsterdam Treaty stipulates that ‘A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities’, which implicates that EU actions on health care issues is broadened. However both Treaties clearly state that incentive measures undertaken by the EU exclude ‘any harmonization of the laws and regulations of the Member States’ (COM (98)230).

4.3. Internal Market Rules and Regulations Related to Health Care Systems of the Member States

The Treaty of Rome, which established the European Economic Community (EEC) provided the basis for a common market, characterized by free movement of people, goods, services, and capital. These four freedoms have continued to lie at the heart of the European idea and, as will become apparent later, have important implications for the development of health policy in Europe. (Mossialos and Palm,2003:3).

The aim of the internal market regulations of the European Community is to reduce barriers to trade and to create free markets to obtain the economic benefits associated with free competition. However, health is not a typical market. The importance of health to the individual, and the need for Member States to ensure equitable access to health care

across their populations, gives rise to a form of market which is not easily subject to the competitive model. For example, risk pooling, third party payment for taxation (through insurance funds or taxation) combined with the fact that historically patients have been dependent on the advice of medical experts to tell them what and how much health care to “consume”, means that patients do not purchase services in a conventional sense, and the scope for inefficient and inappropriate supply is much higher.

Health care systems comprise many components all of which form sub-markets which are subject to Treaty provisions governing the free movement of goods and services, and all these sub-markets have been affected in one way or another by Community legislation.

In this context the Treaty rules governing free movement of goods and services can appear to be rather blunt tools which require careful handling. The ECJ has itself recognized this point, noting in recent rulings that possible benefits to individual patients have to be weighed against the search for equitable access to care and for a secure local supply of services. Both these principles tend to militate against the movement of patients to other countries in large numbers.

The European Court of Justice’s (ECJ) application of EU internal market rules to the health sector also has expanded the influence of the European Community into health policy. Specifically, enforcement of EC competition law by the ECJ and national courts has ensured that health care providers and insurers follow Single European Market rules if they compete in the health market as ‘undertakings’ similar to companies competing in other markets. National health policy makers who do not follow EU legal developments may make the assumption that since

health care provision has traditionally not been subject to EU laws, they may continue to define and implement health policy free from worry about EU regulation. However, Community competition rules prohibit undertakings from participating in anticompetitive activities such as agreements to set prices or abuse of dominant position, under Treaty Articles 81 and 82. Health policy makers ignore these rules at the peril of having their policies challenged in court.

4.3.1. Free Movement of Health Professionals

According to the general European legislation, each doctor has the right to practice medicine in every country of the EU. On 7 March 2002, The European Commission presented a proposal for a Directive on the recognition of professional qualifications to the European Parliament and Council. With this Directive, the Commission introduces a flexible and modern method of coordinating education and training, which lead to automatic recognition of academic titles in the field of professional recognition (Efthimios et al., 2004: 404).

The establishment of the Single European Market also enshrined the fundamental freedom of movement of persons, capital, services and goods throughout the Community (See case study on cross border services). EU legislation on the free movement of professionals, including health professionals, has evolved through a series of directives leading to the current Directive on the recognition of professional qualifications (Directive 2005/36/EC of the European Parliament and the Council on the recognition of professional qualifications. *OJL* 255 (30.9.2005)). The aims of the directive are to ensure that Member States enact uniform, transparent, and non-

discriminatory rules recognizing professional qualifications and experience to allow professionals to work temporarily or permanently throughout the Union.

The Directive 2005/36/EC establishes rules according to which a Member State which makes access to or pursuit of a regulated profession, including health professions, in its territory contingent upon possession of specific professional qualifications shall recognize professional qualifications obtained in another Member State which allow the holder of those qualifications to pursue the same profession there. This proposal does not aim to amend, modify or otherwise interfere with the existing rules on the mutual recognition of professional qualifications. Neither should any measure, taken by Member States in view of implementing this proposal by ensuring that health care is provided according to clear quality and safety standards, constitute new barriers to the free movement of health professionals as regulated by Directive 2005/36/EC (COM(2008) 414).

In the context of the European Union, these conditions are framed first and foremost in the principles of the free movement of persons. More concretely, the doctors' right to move to other Member States is derived from the free movement of workers,[9] the freedom of establishment,[10] and the free movement of services.[11] European secondary legislation crystallizing the free movement of doctors is extensive. It comprises a/o Regulation 1612/68 fighting discrimination, the legislation for co-ordination of the different social security systems (Regulation 1408/71) and the legislation to decide which criteria labour law provisions can be

[9] Articles 39 and following of the EC-Treaty.

[10] Articles 43 and following of the EC-Treaty.

[11] Articles 49 and following of the EC-Treaty.

used in case of a temporary movement of workers (Directive 96/71). Apart from this general European secondary legislation, there is the specific legislation which deals with the mutual recognition of diplomas and titles; for doctors, this is specifically regulated through the so-called "Doctors' Directive 93/16/EEC".[12] The Doctors' Directive has been modified at each enlargement. The Doctors' Directive has therefore been modified by the Act concerning the conditions of accession of the new Member States.[13] The official titles of the relevant diplomas of the new Member States have been added to the 'recognition lists' and the chapter of acquired rights have been adapted.

According to Peeters, the advantages of doctor's cross-border movement cannot be overestimated. He states that staff shortages in the health care sector and the increasing specialization of medical science are only a few reasons. However, this movement should be conditional, as patient's safety is also at stake. Again, the search for a coherent legal framework comes down to the search for a balance of the internal market and public health. He concludes that the new Directive tries to offer some more patient safety by foreseeing more strict procedures for foreign doctors. "For what concerns the applicability of professional rules, it nullifies, for example, the controversial 'country of origin principle' of the proposal for a Service Directive" (Peeters, 2005: 390).

---

[12] Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications, OJ L 165, 7.7.1993, p. 1-24.

[13] Act concerning the conditions of accession of the Czech Republic, the Republic of Estonia, the Republic of Cyprus, the Republic of Latvia, the Republic of Lithuania, the Republic of Hungary, the Republic of Malta, the Republic of Poland, the Republic of Slovenia and the Slovak Republic and the adjustments to the Treaties on which the European Union is founded, *OJ* L 236*,* 23.09.2003, p. 33
http://europa.eu.int/eurlex/lex/en/treaties/dat/12003T/htm/L2003236EN.003301.htm
The modifications can be found at:
http://europa.eu.int/eurlex/lex/en/treaties/dat/12003T/htm/L2003236EN.017901.htm

4.3.2. Free Movement of Patients

An area that has seen the most recent major developments is the free movement of patients.

The basis of recent activities of the European Community in the field of cross-border patient mobility of the European Union is the European Social Agenda for the period 2005 to 2010.[14]

The Commission published in June 2008 the long awaited proposal for a directive on patients' rights in cross-border health care.

As a strategy of establishing consensus among the Member States, the Commission introduced a "high level process of exchange of opinion" and published a communication "Follow-up in the high-level reflection process on patient mobility and health care developments in the European Union".[15] In this communication the European Commission refers to various rulings of the European Court of Justice and stresses that the court has clarified the conditions under which patients may be reimbursed for health care provided in a Member State other than the Member State of affiliation of the patient. A recent communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on "healthier, safer, more confident citizens: a Health and Consumer

[14] COM (2005) 33 final, 9.2.2005.

[15] COM (2004) 301 final, 20.4.2004.

protection Strategy”[16] proposes a program of Community action in the field of health and consumer protection 2007–2013.

The ECJ has developed most of the Community law in the area of patients’ mobility. In 1998, the famous *Kohll and Decker cases* gave the Court its first opportunity to apply the free movement of persons provisions to the health sector. The Court found that Community nationals had the right to obtain medical treatment in any Member State without prior authorization and also to be reimbursed consistent with the tariffs of the state in which they are insured (Lear and Mossialos, 2008: 2). Although there are some earlier judgments of the European Court of Justice that relate to this issue, it is generally held that the seminal ones were those in 1998 concerning *Kohll* and *Decker*, which unleashed a flurry of political and academic discussion about the precise implications of these rulings that established an important principle while offering very little detail of what they meant in practice (Rosenmöller et. al., 2006: 3).

In the Kohll and Decker case, the European Court of Justice made two rulings which many EU member states regarded as a major development in the application of European law to the field of health care. The Luxembourg insurance fund refused to reimburse the claimants on the grounds that, under existing European regulations governing the co-ordination of member states’ social security schemes, they should have obtained prior authorization (E112), however, the ECJ upheld the claimants’ cases under existing Treaty provisions governing the free movement of goods and services.

[16] COM (2005) 115 final, 6.4.2005.

To many Member States these rulings represented an attack on their right to organize their health and social security systems in their own way under *subsidiarity.* The ECJ argued, however, that this discretion could not be used to breach EC law. The ECJ did not declare Regulation 1408/71 invalid, but argued that it did not provide an exhaustive list of the means by which an EU national could obtain medical goods and services in another Member State. The immediate impact of this ruling was to institute a dual system for obtaining reimbursement for cross-border health care, namely:

- under EC Regulation 1408/71, providing for the issue of forms E111 and E112, whereby costs are reimbursed in accordance with the scale of charges in the country of treatment;

- the new "Kohll and Decker option" whereby the insured person obtains treatment abroad and is subsequently reimbursed in accordance with the scale of charges in the country of insurance.

The Kohll and Decker Rulings were followed in July 2001 by the Smits-Peerbooms rulings which have further clarified the application of European law to Member States' health care systems. The claimant argued that the quality of clinical care offered by the German clinic was superior to that available in The Netherlands. In its judgments, the ECJ confirmed that all Member States must comply with Community law when exercising the power to organize their social security systems. The Court further confirmed that medical activities including hospital services fall within the scope of Article 50 of the Treaty (the freedom to provide services within the Community). However, the need to maintain the financial balance of social security systems and the maintenance of

a balanced medical and hospital service open to all may justify a restriction such as is provided for under the system of prior authorization. The Court went on to comment on the conditions under which authorization should be given under existing EU legislation. The treatment given should be regarded as "normal" in international professional circles, and must be required by the patient's condition. Authorization can be refused only if the same or equally effective treatment can be obtained *without undue delay* at an establishment having a contract with the insured person's sickness insurance fund. While the idea of 'undue delay' has not been completely defined, it should be noted that some Member States with lengthy waiting times for a number of medical conditions, may find it difficult to justify refusing authorization for treatment abroad.(The Internal Market and Health Services). Furthermore in the case of Smits- Peerbooms, some researchers draw attention to the point that the ECJ did not define what it meant by criteria based on "international medical science" (rather than what is considered normal treatment in Netherlands professional circles), presumably on the assumption that there is a common medical paradigm in Europe (and the rest of the world) (Mossialos and McKee, 2001: 5-20).

In December 2001, a conference held in Ghent organized by the Belgian presidency of the European Union focused the attention of many more health policy-makers on the impact of European law on health care (McKee et al., 2002; Mossialos and McKee, 2002). The debate continued under the Spanish presidency of the European Union, in particular at a conference held in Malaga in February 2002, leading to the Council of Ministers calling, in June 2002, for the creation of a high-level process of reflection on patient mobility and health care developments in the European Union. In December 2002 this led to a

report under the auspices of three commissioners (health, social and internal market) that made a series of 19 recommendations in five main areas and the Commission responded to these recommendations in a communication in the spring of 2004 (European Commission, 2004) defining the following areas of work: rights and duties of patients; sharing spare capacity and transnational care; health professionals; European centers of reference; health technology assessment; health care systems information strategy; motivation for and scope of cross-border care; data protection; e-health; improving integration of health objectives into all European policies and activities; establishing a mechanism to support cooperation on health services and medical care; developing a shared European vision for health care systems; and responding to enlargement through investment in health and health infrastructure. Additionally it recommended the creation of a High Level Group on Health Services and Medical Care, which would subsequently develop working groups on issues such as cross-border health care; health professionals; centers of reference; health technology assessment; information and e-health; health impact assessments; patient safety and e-health. The first recommendations emerged in December 2004 (Rosenmöller, et. al., 2006: 2, 4).

The Commission proposes the establishment of a Community framework for cross-border healthcare, as set out in the accompanying proposal for a directive. As well as setting out relevant legal definitions and general provisions, this is structured around three main areas:

- common principles in all EU health care systems

- a specific framework for cross-border healthcare

- European cooperation on healthcare

This proposal is based on Article 95 of the EC Treaty on the establishment and functioning of the internal market. It is also consistent with the provisions of Article 152 of the EC Treaty on public health and respects the responsibilities of the Member States for the organization and delivery of health services and medical care as interpreted by the Court of Justice. The directive will provide sufficient clarity about the rules to be applied for the reimbursement of healthcare provided in other Member States and how the rights of the patients will be implemented in practice in line with the case law of the Court of justice. The directive reflects the following principles:

- Any non-hospital care to which citizens are entitled in their own Member State, they may also seek in any other Member State without prior authorization, and be reimbursed up to the level of reimbursement provided by their own system.

- Any hospital care to which they are entitled in their own Member State they may also seek in any other Member State. The directive allows Member States to provide for a system of prior authorization for reimbursement of costs for hospital care provided in another Member State, if Member States can provide evidence that the outflow of patients resulting from implementation of this Directive has such an impact that it seriously undermines or is likely to seriously undermine the planning and rationalization carried out in the hospital sector. The costs of such hospital care provided in another Member State should also be reimbursed by the Member State of

> affiliation at least up to the level of costs that would have been assumed had the same or similar healthcare been provided in the Member State of affiliation.[17]

According to Mossialos and Palm, it would appear from these latest judgments, that the ECJ has not only radically restricted member States' discretion to determine their own authorization policies; it also seems to have changed rules of coverage under the classic social security coordination system. Consequently it seems that a revision of the legal framework regulating access to healthcare across the EU will be necessary (Mossialos and Palm, 2003). In addition, the creation of an internal healthcare market could provide a firm basis for initiating a common reflection on a nonbinding frame of reference for quality standards, the criteria for good medical practices, the rules governing the equivalence of medical skills and services, hospital accreditation etc. (Palm et al., 2000).

To conclude, in the future the internal market rules and regulations, especially in the area of free movement of people and services will have more impact on the health care issues which could be qualified as 'policy diffusion'. As Sieveking says "The judgments of the Court of Justice concerning the patients' rights to cross-border health and long-term care caused not only an increase of personal rights but even more a fundamental change in understanding European health policy…We

[17] Communication From The Commission A Community framework on the application of patients' rights in cross-border healthcare {SEC(2008) 2183}.

will witness the emergence of a new European area of health systems" (Sieveking, 2007: 49).

4.4. Social Policy in the EU and Implications for the Health Care Policy of the Member States

Social policy was considered by the EU as a subsidiary issue for a long period. During the enlargement, European Social Model was not an important driver in shaping CEE social policy. Furthermore the 'transition process' of the CEE countries has started in 1989 before The EU recognized the right of the countries of Central and Eastern Europe (CEE) to join the European Union at the Copenhagen European Council in June 1993. As a consequence the EU was not yet ready to consider a potential enlargement and its requirements. As Ferge and Juhasz stated, "the EU left the steering role in the transformation of the eastern countries to the monetarist supranational agencies that were already used to dealing with the CEE countries" (Ferge and Juhasz, 2004: 2).

The World Bank and, in a less visible way, the IMF played major roles in the early years by shaping not only the economy but also the social policy of Central and Eastern Europe.

The European Social Model started to play some role from about the mid-1990s, mainly in fields related simultaneously to the social and the political spheres. The provision of health care as an aspect of health policy can be seen as an important part of Social Policy that contains various areas, e.g. pensions, education, employment. Health care as a main field of health policy is a matter of organization of health services, according to various specializations and geographic coverage. The

extent to which any given person has access to the health care system of a state in the form of social benefits is called “social health care”.[18]

As far as social health care is concerned, the European ideal is as comprehensive a degree of compulsory coverage as possible. This principle governs social health care, which sharply distinguishes Europe from the other continents, where such forms of care are either open to choice or even an incentive offered by the respective employers. Compulsory coverage itself is a manifestation of the principle of solidarity, which is dominant in the organization of social health care in EU Member States. The principle of solidarity may be located at three levels: in terms of the integration into the system, in terms of the funding of the system, and in terms of benefits insured by the system. Except for this essential feature the Member States’ systems have very little in common. All these systems may be seen as specific emanations of the two broad models of social health care: the continental model of social insurance or the Beveridgean model of a national system of health care. Most European countries attempt to establish universal systems where access to services is almost free at the point of use. The idea of universal access remains a core objective in European health policies (European Commission, 2004).

In practice, the EU uses some tools to affect the health policies of the member states. One of them is the Open Method of Coordination which is established at the Lisbon Agenda of 2000. At the beginning of the European Convention, the OMC was not a central issue, however, by

[18] For the following see Hatzopoulos 2005. See also Igl 1999; Hervey 2002 and 2003; McKee, Mossialos, Baeten 2002; Mossialios and McKee 2002; Nickless 2002; Palm 2002; Tiemann 2006. Emphasising the legal aspects see Hervey, McHale, 2005.

creating a community of policy-makers which uses a common terminology, it became a ‘legitimising discourse’ (Radaelli 2003b: 8). In the areas where harmonization of legislation is not possible as in the case of health policy, OMC helps exchange of best practices and puts emphasize on the mutual learning. Although health and long-term care are among the OMC procedures that are conducted by the Social Protection Committee, application of the Services Directive has met fierce opposition from the health related lobbying groups. In this respect, health care is not one of the policies where there is a deliberate attempt to use the OMC as the main ‘working method; instead, as Radaelli (2003b: 31) states, health care in a second group of policies in which “EU policy-makers manifested their intention to use the OMC, but only a minimal component of the instruments and practice at work in these policies correspond to the method”.

Coordinated by the European Commission, the High Level Process on Patient Mobility was established in February 2003. Another tool is the PHARE which is devoted to facilitate the transition process in CEECs. To support the health reform projects which were initiated firstly in Hungary, Poland and Czechoslovakia (previously), a total € 105 million was transferred through the PHARE to CEECs between the years of 1990 and 1998. Sustainable financing, hospital management, information systems, regulation in pharmaceutical sector, primary care development and human resource management are the main areas the financial resources from the PHARE committed to support the health care systems in the countries in transition.

Representatives of Member States participating in the High Level Committee on Health, a six-monthly informal policy meeting between the Commission and policy-makers from the Member States, argued for

health and enlargement to be higher on the Commission's agenda. Consequently the Public Health Unit in what was then Directorate-Generale V (DG V) organized a study partially funded by EC Phare Consensus. This led to the publication of the *Commission Staff Working Paper SEC* (1999)713 on health and enlargement (European Commission 1999). Even though the document recognized the differences between accession countries, it outlined a series of key issues present to different degrees in all countries: the lack of well-defined modern public health policy concepts, increases in communicable diseases together with a decline in vaccination coverage, increases in drug use, the need for better emergency facilities, the low social status of health professionals, the lack of involvement of civil society and the negative health impact of environmental degradation. The WHO Regional Office for Europe, producing the "*Highlights on Health in the Candidate Countries*" series (European Commission 2003) analyses and give an overview of the health and health-related situation in each country. The aims of the project is to improve, strengthen and support the candidate countries in their task of analyzing, evaluating and monitoring public health issues, in accordance with Pillar C of the Health Monitoring Programme (HMP) and Article 1(2) and Annex 1(c) to Decision No.1400/97/EC of the European Parliament and the Council of Europe (WHO Regional Office for Europe, 2003: 1).

In March 2003 the Commission and the Council presented a joint report on supporting national strategies for the future of health care and care for the elderly (European Commission and Council of the European Union, 2003). This Report is based on the Member State's responses to a questionnaire on health and long-term care for the elderly, sent by the Social Protection Committee. The Joint Report takes up the three broad

goals endorsed by the Barcelona European Council of March 2002: access for all regardless of income or wealth; a high level of quality of care; and financial sustainability of care systems. It addresses a number of common challenges and issues, such as new technologies and treatments; improved wellbeing and patient information; demographic ageing. It raises many issues related to access, quality and financial sustainability of health care and long-term care. It states that there is scope for greater cooperation in the field of quality of service delivery and quality assessment, particularly from the perspective of greater cross-border mobility of patients and of enlargement. Regarding financial sustainability, the report points to the challenge of ensuring that resources can be deployed in the interest of efficiency and cost-effectiveness. Issues are also raised on employment, including aspects such as retaining staff, recruiting and training of new staff, opportunities to increase European employment levels, and gender issues in the care sector. The report concludes that a process of mutual learning and cooperative exchange should continue on the basis of the issues identified. It focuses particularly on improvement of the information base, methods of cooperation and the need to pay particular attention to employment issues. The report does not, however, propose to apply the Open Method of Coordination in the field of health care; nor does it incorporate the Commission's proposal (European Commission, 2002) that the cooperative exchange should focus on the drawing up of indicators. Following endorsement by the Council, the Spring European Council (European Council, 2003) in Brussels in March welcomed the report and the intensification of the cooperative exchange, as the basis for further proposals which the Commission should present by autumn 2003. On 17 February 2003 the Commission adopted a Communication, in which it sets out a detailed roadmap for a progressive replacement of the current paper forms, needed for health treatment during a temporary stay in another country,

by a European Health Insurance Card (European Commission, 2003). This should be operational by June 2004. It follows the decision of the European Council of Barcelona of March 2002 to create such a Card, in the framework of the coordination of the national social security schemes (Regulation 1408/71). The Card will first replace the existing E111 form for short stays such as holidays and then, in a second phase, all the other forms used for temporary stays: employees posted to another country (E128), international road transport (E110), study (E128) and job seekers (E119). In a third phase, it will take the form of an electronic 'smart' card. The card will simplify procedures but not change EU citizens' rights and obligations.

> "The EU must catch the wind of economic upturn and generate sustainable growth over a long period. To achieve this, the EU must pursue a systematic policy of modernization that delivers structural reforms, accelerates absorption of new technology, improves European research, promotes the reform of social welfare, health and pensions, and creates e-literate workforce whose ideas find faster expression in the marketplace". (European Commission, 2000: 1; see also European Commission, 1997, 1999).

CHAPTER V

HUNGARY: AN ANALYTICAL APPROACH TO THE TRANSITION PROCESSES OF THE HEALTH CARE SYSTEM

In this chapter, the thesis examines the transition process of the health care system of Hungary based on the main reform efforts in the health care system. The aim of this chapter is to identify the domestic health care policy preferences and the main drivers of the reform efforts in Hungary. In this context, the thesis will try to explore the impacts of Europeanization and New Institutionalism on the changes in the health care systems, especially in the health care policy-making processes of Hungary.

In the first part of this chapter, the main reasons and drivers of the health care reform will be identified to show that whether the transition of the health care system of Hungary was unavoidable under those circumstances. Second, the main characteristics and tendencies of the Hungarian Socialist Party (HSP) as the main political actor which initiates the radical reform attempts in the country will be discussed in order to examine the political side of the transition process of the health care system of Hungary. In the third part of this chapter, the thesis will identify the main healthcare reform efforts based on the identifier

transition attempts and governmental periods and the main health related laws and regulations will be given place[19].

5.1. Rationales for Transition of Health Care System

The aim of this section is to determine if the transition of the health care systems of the case countries to the Bismarckian Health System is a deliberate action which strengthens the Europeanization perspective carrying some implications for the concept, or if it is just an attempt to escape from an unsustainable health care system as a one-way road which turns 'back to Bismarck'.

With this respect, the thesis classifies the rationales for transition of health care systems of Hungary under five main factors:

1. Health status of the population was deteriorated

2. There was a general distrust of the central government, whose budget was seen as a black hole swallowing people's money with little evidence that it was spent wisely.

3. The over-centralized health care delivery system was seen as inefficient, unable to provide services to meet the population's changing needs. The oversized hospital sector sucked up the

[19] All laws and regulations have been published in the Hungarian Gazette (Magyar Közlöny), and available only in Hungarian. Most of the health related laws and regulations are available in English on the web-site of the Ministry of Health, Social and Family Affairs, available at www.eum.hu/english.

majority of the health care budget, and the system was providing care at unnecessarily high levels at a cost that was increasingly thought unaffordable.

4. Resource allocation was subject to political influence, and as a result geographical inequalities arose, as well as inequalities among specialties.

5. The majority of health care workers were becoming increasingly unsatisfied with the slowly deteriorating working conditions, the decreasing prestige of the profession and the low salaries, as the income from informal payments was shrinking (Gaal, 2004: 99,100)

In Hungary, the improvements made in the 1950s in the health status of the population slowed in the 1960s. Central planning allowed little flexibility in response to changing circumstances and weighted the health sector heavily towards achieving quantitative development. Moreover, resource allocation was subject to political influence, which resulted in inequalities in service provision in terms of geographical locations and specialties. Although Act II on Health of 1972 confirmed that access to health services was a right linked to citizenship and promised comprehensive coverage free-of-charge at the point of use (1972/1), an increasing gap developed between rhetoric and reality. The system was suffering from excess capacities, deteriorating service quality and widespread informal payments at the same time. The need for radical health care reforms became increasingly apparent in the 1980s. The widening gap in health status between Hungary and western European countries called for change and the softening political climate opened the way for reform (Gaal, 2004: 7).

Health care reforms in Hungary began in the last years of the communist regime of the mid 1980s, when the continuously deepening recession and increasing pressure from the emerging political opposition allowed a reform-oriented, liberal faction of the communist party to take over government and formulate reform policies for the reorganization of the state-socialist health care system.

5.2. The Role of the Hungarian Socialist Party in the Transition Process of Hungary

The Hungarian Socialist Party (HSP) has a fundamental importance in the reform and transition process of the Hungarian healthcare system. The Third Way as a 'response both to the global environment and domestic political context'(Holmes, 2009:179) by the British Labour Party has mobilized all social-democratic parties in Europe against the 'old politics of retrenchment' (Scarbrough, 2000). They have answered to the changing global circumstances in their own way but to a great extent under the impact of the original ideas of a Third Way (Cuperus and Kandel, 1998). In this regard, The Hungarian Socialist Party (HSP) emerged first among the social-democratic parties of the Central European region, before the collapse of the former regime and played an initiative role in the power transition. It emerged in October 1989 before the first free elections in May 1990. The pragmatic tradition of the party's development dates back to the technocratic party reformers in the eighties. The ruling party in Hungary (HSWP-Hungarian Socialist Workers Party) began economic reforms very early and its technocratic elite pioneered economic reform and the opening towards the West.

This technocratic–pragmatic elite played an important role in the preparation of the economic systemic change and in the foundation of

the HSP in 1989. It legitimized the Left in this turbulent period and it was one of the main actors of systemic change in Hungary. As the leading coalition party in 1994–1998, the HSP proved its social-democratization and Western orientation by its support for further democratization, privatization and 'Europeanization' (Agh, 2002: 270).

When we look at the party documents prepared for the November 2000 party congress (the Seventh Congress of the HSP) which were important for the assessment of the HSP reform and its move towards a 'Third Way' approach, we see that the HSP has launched a new drive for a participative democracy. The HSP claims to have changed its policies to more active and innovative ones since the early 1999 because the national-conservative government was not ready to follow the rules of consensual democracy. Therefore, the long term *Party Program* was discussed and accepted by the subsequent party congress in November 2000. The Party Program has used the 'Third Way' terminology and introduced its perspectives as a conceptual framework for Hungary's development (Agh, 2002: 283). In April 2006, the Hungarian Socialist Party the ruling centre-left coalition led by Ferenc Gyurcsany took 210 of the 386 seats in the lower house of parliament, against only 164 for the conservative opposition led by Fidesz. With links to the communist-era elite, he is now a keen Blairite, Atlanticist and market-friendly, quite unlike the older ex-communists who still dominate his Socialist Party. The government promises "reform without austerity" and intends to bring in insurance-based health-care (The economist, April 27, 2006).

5.3. Transition of the Hungarian Health Care System in Stages

With the severe economic crisis and the collapse of the communist dictatorship, Hungary witnessed the beginning of a thorough health sector reform. Replacing the tax-based financing of the state-socialist system, Hungary reverted to the earlier Bismarckian model of compulsory social insurance in 1990. New performance-based provider payment methods were introduced together with cost-containment mechanisms to ensure that the preset budgets were not exceeded. Ownership of the majority of hospitals and other health care facilities was transferred to local governments. The vast majority of medical doctors and other health workers remained salaried public employees (Gaal, 2005: 37).

The Hungarian health care reform aims to improve the health status of the population, the increase of life expectancy at birth and to facilitate the quality of life determined by health and to provide citizens with equal opportunities to access generally accepted health services within the mandatory health insurance system.[20]

This health care policy objective is parallel to the healthcare objective of the EU. The most important operational principle of the health care system is 'solidarity', which means that the insured pay income-proportionate, rather than risk-proportionate, contribution fees.

[20] See the official web site of Hungarian Ministry of Health, http://www.eum.hu/english/main-policy-objectives/reform-of-the-health

Table 5. 1. Healthcare Reforms by Years in Hungary

1987: Experiment on Homogenous Disease Groups (HDG) launched – first in Europe. Hungarian Medical Chamber set up.
1989: Private practice authorized.
1990: Switch from tax-based funding to compulsory insurance. Ownership of health facilities transferred to local governments.
1991: Establishment of the National Public Health Service (responsibility for local hygiene stations transferred from local governments).
1992: Social insurance fund divided into a Pension Fund and a Health-Insurance Fund.
Universal entitlement to health care eliminated by Parliament and conditions for eligibility defined. Family doctor network created, allowing free choice for patients; capitation-based payment introduced.
1993: Voluntary Mutual Health Insurance Fund (supplementary insurance operated by private non-profit institutions) authorized. Outpatient-care remuneration based partly on a fee-for-service scheme introduced. Hospital-care remuneration on an HDG-type scheme introduced.
1994: New National Health Promotion Strategy adopted by the Government.
1995: Hospital capacity reduction program initiated, with almost 20 000 hospital beds abolished in the period to 1997.
1996: Restoration of universal entitlement to health care.
1997: Act on Health Care.
1998: Abolition of the Health-Insurance Self-Government.
1999: Pilot projects on managed care launched.
2000: Privatization of the practices of general practitioners introduced.
2002: 50% wage increase for health care employees working as civil servants approved (effective in 2003).
2004: New spending rules set up for hospital and pharmaceutical subsidies to avoid expenditures overruns implemented. 20% of the population covered by managed care.

Source: Adopted from Orosz and Burns, 2000: 29 and Gaal, 2005.

5.3.1. Establishment of the Compulsory Social Insurance Model and Decentralization in the Health Care System: 1988-1994

In Hungary the institution of social insurance remained formally in place during the communist era as well, which concerned financial provisions (sickness benefit) and financed social expenses (pensions, family support). The problems of the communist system accumulated strongly before the change of the regime. To solve these difficulties, it was suggested that the system should revert to the pre-second world war insurance traditions, complemented with social insurance financing. In 1989, the financing of the operational costs of health care became the responsibility of social insurance, whereas the financing of certain social tasks (family allowance) was taken over by the state budget. In 1992, the social insurance fund was divided into a pension fund and a health insurance fund with separate administrations (Hungarian Health System Scan, January, 2007: 3).

In 1987, the Information Centre for Health Care was set up, which was responsible for the DRG project, and has been the key institution in designing and administering provider payment methods.[21]

The proposals of the Reform Secretariat outlined the principles of the new health care system. A key element was that sources of health care financing should be separated from the central government budget, so that revenues could not be used for other purposes. Another key principle was the so-called sector neutrality, that is, health care financing should not discriminate against private providers. The

[21]The establishment of the Information Centre for Health Care (ICHC), which piloted and runs the performance based provider payment methods of FFS points and Hungarian DRGs in specialist outpatient and in patient care: Order No. 3/1987. (Eü.K. 3.) EüM of the Minister of Health on the Information Centre for Health Care of Ministry of Health (see also Order No. 3/1991. (NK. 23.) NM of Minister of Welfare and Deed of Foundation in Welfare Gazette 1995/13)

communist era saw the first changes implemented. In 1989 the system was switched from tax-based financing to compulsory social insurance.[22] In 1990, the budget of the health service was transferred to the newly established Social Insurance Fund, referred to as the "fund exchange".[23] Since the Social Insurance Fund was meant to cover the recurrent costs of services, funds for capital costs remained in the central government budget. In 1989, full private health care entrepreneurship was legalized, and private providers were permitted.[24]

Before dealing with decentralization efforts in the health care system of Hungary, it would be useful to make a brief definition of decentralization which is generally used to mean a shift in power and responsibility from the higher to the lower levels in a governmental system. Hunter at al defines the decentralization as a "shift in power relationships and in the distribution of tasks between levels of government and the various stakeholders to be found at each level" (Hunter et al. 1998: 310). The *1990 Local Government Act* created the provider side of the new contract model.[25] The ownership of primary care surgeries, polyclinics and hospitals was devolved from the national to local government along with the responsibility to ensure the supply of health care services to the

[22] The separation of the Social Insurance Fund from the national government budget:: Act XXI of 1988 on the Social Insurance Fund (promulgated: 31/12/1988)

[23] The "fund exchange": health services are financed from the Social Insurance Fund: Act XLVIII of 1989 on the Social Insurance Fund's Budget of 1990 (promulgated: 27/12/1989)

[24] "full" private providers are allowed to be established in the area of health and social services: Decree No. 113/1989. (XI. 15.) MT of the Ministerial Council on Social and Health Enterprises and Decree No. 30/1989. (XI. 15.) SZEM of the Minister of Social Affairs & Health on the Practice of Medicine, Clinical Psychology and Other Health and Social Services

[25] Ownership of most public health care facilities is transferred to local governments (Article 107, section 1, point c): Act LXV of 1990 on Local Government (promulgated: 14/08/1990; see also Act XX of 1991 on the Scope of Duties and Division of Authority between Local Governments and their Organs, the National Government Representatives and Certain Centrally Controlled Organs)

local population, the so-called territorial supply obligation. The new owners became responsible for maintenance and investment costs, but the central government established the system of "earmarked and target subsidies" to support local governments with conditional and matching grants.[26]

As part of the reform of public health and the modernization of health care system administration, the National Public Health and Medical Officer Service (NPHMOS) was established as a state agency in 1991.[27] The NPHMOS was built on the State Supervision of Public Hygiene and Infectious Diseases of the communist regime and managed to preserve its well organized service of infectious diseases surveillance, immunization and public hygiene. The government envisaged the wider role of public health and health promotion, but the Service had to build on the available human resources. In addition the Service was assigned the task of professional supervision and coordination of the delivery of health care.[28]

The financing system was developed further after a debate on whether to move towards a single- or multi-insurance model.[29] A single-insurance model was accepted, but left open the option of competition

---

[26] Assisting local governments for financing capital costs of their facilities including hospitals, medical equipment, etc.: Act LXXXIX of 1992 on the System of Earmarked and Target Subsidies for Local Governments (promulgated: 31/12/1992)

[27] Act XI of 1991 on the National Public Health and Medical Officer Service (promulgated: 09/04/1991) and Decree No. 7/1991. (IV. 26.) NM of the Minister of Welfare on the Organisation and Operation of the National Public Health and Medical Officer Service

[28] Decree No. 8/1993. (III. 31.) NM of the Minister of Welfare on the Professional Supervision of Health Care Institutions

[29] The parliament sets out the main directions of the pension and health insurance system: Resolution No. 60/1991. (X. 29.) OGY of the National Assembly on Social Insurance

between insurance schemes in the future. It was decided that the Social Insurance Fund would be divided into a health and a pension fund, and that both funds would have a quasi-public supervision consisting of the representatives of contributors, that is employers and employees.[30] In 1992, the social insurance contribution was split into health insurance and pension insurance contribution.[31] The Social Insurance Fund was divided into the HIF and the Pension Insurance Fund[32] and was made self-governing after the election of trade union representatives (as representatives of employees) in 1993.[33] Right after the establishment of the Health Insurance Self Government, the administration of the former Social Insurance Fund was divided into two, as well, and the National Health Insurance Fund Administration (NHIFA) was put under the direct control of the Self Government.[34] People were allowed to choose their family physicians[35] and the capitation payment and

[30] Act LXXXIV of 1991 on the Self Governance of Social Insurance (promulgated: 28/12/1991)

[31] Act IX of 1992 on the Amendment and Complement of Act II of 1975 on Social Insurance (promulgated: 09/03/1992)

[32]Division of the Social Insurance Fund into health insurance and pension funds: Act X of 1992 on the Social Insurance Fund's Budget of 1992 and the Amendment of Act XXI of 1988 on the Social Insurance Fund (promulgated: 09/03/1992)

[33] Act XII of 1993 on the Election Rules of Social Insurance Representatives (promulgated: 12/03/1993) and its executive orders of Decree No. 5/1993. (III. 26.) BM and 6/1993. (III. 26.) BM of the Minister of the Interior

[34] As of July 1993, the Social Insurance Fund Administration is divided into the National Health Insurance Fund Administration and the National Pension Insurance Administration: Government: Decree No. 91/1993. (VI. 9.) Korm. on the Establishment of the National Pension Insurance Administration and the National Health Insurance Fund Administration, and their Administrative Organs and Other Measures in Connection with this

[35] Government Decree No. 55/1992. (III. 21.) Korm. on the Amendment of Decree No. 16/1972. (IV. 29.) MT on the Executive Order of Act II of 1972 on Health and Decree No. 6/1992. (III. 31.) NM of the Minister of Welfare on the Family Physician and Paediatric Primary Care Services

The former district doctor system is separated from hospitals and renamed as "family physician service". Free choice of family physician and family paediatrician was introduced and regulation of professional standards including family doctor specialization to be obtained

contracting of family doctor services were introduced.[36] Family doctors were encouraged to become private and contract with the local government for the provision of primary care services, with surgeries and equipment still owned by the local government, which became known as the scheme of "functional privatization".

At the end of 1993, Parliament created the legal framework for the establishment of non-profit health insurance,[37] and in 1994 the Hungarian Medical Chamber and the Hungarian Chamber of Pharmacists began to operate on a self-regulatory basis, with compulsory membership for practicing doctors and pharmacists.[38] The government was less cautious concerning the pharmaceutical sector. National drug companies, the wholesale and the retail industry were mostly privatized along with the liberalization of the pharmaceutical market. It is not surprising that rising drug expenditure became one of the most important sources of the HIF's deficit, which continuously puzzled the successive governments. By the end of the first governmental period, the foundations of the new model of the Hungarian health care system had been laid down. There was a single monopolistic purchaser, the NHIFA, who contracted with service providers, mainly in the public but also in a growing private sector of family doctor services and pharmacies. Supervision of the HIF and the control of the purchaser were delegated to the quasi-public Health Insurance Self Government, but many purchasing decisions were made

---

[36] Government Decree No. 79/1992. (IV. 12.) Korm. on the Social Insurance Financing of Health Services in 1992

[37] Act XCVI of 1993 on Voluntary Mutual Insurance Funds (promulgated: 06/12/1993)

[38] Act XXVIII of 1994 on the Hungarian Medical Chamber (promulgated: 05/04/1994) and Act LI of 1994 on the Hungarian Chamber of Pharmacists (promulgated: 07/05/1994)

by the national government and the National Assembly, for example, budget-setting, financial resource allocation and the choice of payment methods. The transition of the economy was well under way, and began to show the signs of recovery in 1994 (Gaal, 2004).

5.3.2. Cost Containment Objective in the Health Care System: 1995-2002

The first significant measure of the present government in June 1995 was not favorable for the health sector. The government had anticipated an economic crisis as GDP growth slowed down, and inflation started to rise again coupled with a substantial deficit of the state budget. In this context the health sector was seen as a potential threat to fiscal balance, and reform measures aimed to achieve the new priority objective of cost-containment. The first economic stabilization package was introduced in the middle of 1995 and targeted the welfare provisions, including health services. On the financing side, the next year's health care budget was cut, and reached its lowest level in real terms since 1990.[39] Dental services were excluded from HIF coverage, subsidies on spa treatment were removed, and a co-payment for patient transport was introduced.[40] However, shifting costs to patients was somewhat counterbalanced insofar as the government offered tax rebates for the purchase of voluntary non-profit health insurance.[41]

---

[39] Act LXXIII of 1995 on the Social Insurance Funds' Budget of 1995 and the Payment Methods for In-kind Benefits (promulgated: 14/07/1995)

[40] Act XLVIII of 1995 on the Amendments of Various Acts for the Purpose of Economic Stabilization (promulgated: 05/06/1995), its executive orders of Government Decree No. 69/1995. (VI. 17.) Korm, Government Decree No. 70/1995. (VI. 17.) Korm. And Government Decree No. 71/1995. (VI. 17.) Korm

[41] Act CXVII of 1995 on Personal Income Tax (promulgated: 22/12/1995)

The revenue-side strategy was comprised of three components: widening of the social insurance contribution base, decreasing the employer health insurance contribution rate and introducing a lump-sum tax (hypothecated health care).[42] All these measures aimed to increase HIF revenue by mitigating evasion of the social insurance contribution. Since the establishment of the Social Insurance Fund, under-reporting of income and arrearage had been general techniques to avoid paying the contribution. Contribution rates for health and pension insurance were indeed high, 54% of the gross salary, including a 23.5% health insurance contribution. It is interesting to note that the government deliberately introduced a new hypothecated tax rather than determining a fixed minimum level of social insurance contribution. The Constitutional Court ruled many measures of the first economic stabilization package unconstitutional on the grounds that in an insurance relationship the parties could not freely modify the terms of the agreement, while there were no such restrictions for tax-funded services. Moreover, some analysts viewed this measure as the first step towards recentralization of the HIF.

During the new cost-containment era, the government considered the extensive rights of the HIF on budgetary decisions as a potential threat to the planned cuts of the HIF budget. Therefore, it curtailed those rights in 1996.[43] In addition, the government weakened the self-governance of both the HIF and the Pension Insurance Fund through

---

[42] Act LXXXVII of 1996 on the Amendment of Act II of 1975 on Social Insurance (promulgated: 16/11/1996 and Act LXXX of 1997 on those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services (promulgated: 25/07/1997) and its executive order of Government Decree No. 195/1997. (XI. 5.) Korm.

[43] Act XLVII of 1996 on the Amendment of Act LXXXIV of 1991 on the Self Governance of Social Insurance (promulgated: 07/06/1996) and Act CXXI of 1996 on the Amendment of Act XXXVIII of 1992 and Related Laws (promulgated: 21/12/1996)

restructuring in 1997.[44] The number of self-government representatives was decreased. Members were no longer elected, but delegated. This clause was found unconstitutional in 1998,[45] but this ruling of the Constitutional Court lost its significance since the succeeding government abolished self-governance altogether.[46]

The last significant legislative package of this period came in the form of new laws for social insurance,[47] social health insurance[48] and health.[49] Apart from a couple of new institutions, like the National Health Council, or the hospital supervisory councils, these acts did not create new reform principles, or considerable change in the foundation of the health care system.

The government of 1994–1998 successfully implemented a strict cost containment policy, which resulted in a significant cut in the health care budget. By the end of 1997 health care expenditures were almost 30% lower in real terms than in 1990, while in the same year the GDP increased by 4.6%. Preoccupation with economic stabilization had left little time for thinking about the future of the health care system. Nevertheless, within the already running World Bank/Ministry of Welfare

---

[44] Act XLVIII of 1997 on Amendment of Various Acts in Connection with the Self Governance of Social Insurance (promulgated: 11/06/1997). With this legislation self governments are not elected and the number of representatives are decreased.

[45] Ruling No. 16/1998. (V. 8.) AB of the Constitutional Court

[46] The government abolishes the self governance of the social insurance funds and reinstates government supervision: Act XXXIX of 1998 on the State Supervision of Social Insurance Funds and their Administration (promulgated: 15/07/1998)

[47] Act LXXX of 1997 on those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services (promulgated: 25/07/1997) and its executive order of Government Decree No. 195/1997. (XI. 5.) Korm.

[48] Act LXXXIII of 1997 on the Services of Compulsory Health Insurance (promulgated: 25/07/1997) and its executive order of Government Decree No. 217/1997. (XII. 1.) Korm.

[49] Act CLIV of 1997 on Health (promulgated: 23/12/1997)

project a regional modernization project was launched. In addition, the Ministry of Finance prepared a proposal in 1998 envisaging a reform of the financing side via competing health insurance funds. The government had no time left to debate and put the idea into practice, since the 1998 elections brought the opposition parties into power.

One of the first measures of the present government was to abolish the self-government of the social insurance funds, thereby taking full control over the health insurance fund (HIF) and its administration (NHIFA). The measure brought the government into a good position in terms of cost control, and also of a planned reform of the HIF. Control of the NHIFA was transferred to the Prime Minister's Office[50], which was itself strengthened by adopting a chancellery model[51]. In addition, the present government ceased the World Bank supported regional pilot project. The Secretariat for the Supervision of the Social Insurance Funds of the Prime Minister's Office proposed a model of competing health insurance funds, which was finally dropped by the prime minister. The control of the NHIFA was shifted to the Ministry of Finance[52], and the Ministry of Health regained its primacy in health policy-making. Instead of reforming the financing side, the policy focus was shifted to the delivery system, but against the background of the persistent efforts to contain overall health expenditure.

[50] Government Decree No. 131/1998. (VII. 23.) Korm on the Scope of Duties and Authority Concerning the Control of Social Insurance Administration

[51] Government Decree No. 137/1998. (VIII. 18.) Korm. on the Prime Minister's Office

[52] As of 21 June 1999, the control of social insurance administration is shifted to the Ministry of Finance: Government Decree No. 90/1999. (VI. 21.) Korm on the Amendment of Certain Regulations Concerning the Control of Social Insurance Administration

An essential event of this period was the announcement of the National Health Program. In this period the institution of the “right of practice” was introduced in primary care,[53] which transformed the right of operation into a right of assets, thus making the “right of practice” on certain professional conditions marketable. After the rejection of health insurance competition, the first delivery-side reform measure of the Ministry of Health came in the beginning of 2000, when the “practice right” was introduced with the objective of creating a market for family doctor practices The government offered subsidized loans for family doctors to help them buy the surgical and other equipment from the local government. During the second half of 2000, however, nothing significant happened, as far as the reform of the delivery system was concerned, but the government continued its battle against rising pharmaceutical expenditure. The Social Insurance Price and Subsidy Committee was established,[54] and negotiated a long-term agreement with the representatives of the pharmaceutical industry to secure a price increase below inflation level over a three-year period. On the revenue side of the HIF, the ceiling on employee health insurance contributions was abolished.[55]

---

[53] Act II of 2000 on Independent Medical Practice (promulgated: 11/02/2000) and Government Decree No. 18/2000. (II. 25.) Korm on the Procurement and Withdrawal of Family Doctor’s Right to Practice, and the Terms and Conditions of Loans for Procurement of the Tangible and Intangible Assets and Right to Practice Required for Family Doctor’s Practice

[54] Government Decree No. 112/2000. (VI. 29.) Korm on the Scope of Duties and Authority of the Social Insurance Price and Subsidy Committee

[55]As of 1 January 2001, the ceiling on the health insurance contribution of employees is abolished (Article 153, section 1): Act CXIII of 2000 on the Amendment of Various Laws on Taxes, Contributions and Other Government Revenues (promulgated: 14/11/2000)

The *1996 Capacity Act* was repealed,[56] and a 10-year public health action program was elaborated to increase life expectancy of men and women to 70 and 78 years, respectively.[57] The program was coordinated by a project unit in the NPHMOS and continued and later expanded and updated by the current government. The reform of the delivery system continued with the establishment of the freelance medical doctor status, and the encouragement of the corporatization of public providers.[58] The 2002 general elections brought the Hungarian Socialist Party and the Alliance of Free Democrats back to power. The whole period of 1998–2002 was characterized by uncertainty about the desired direction of health care reform and the search for the way forward. On the other hand, uncertainty implied cautious – hence reversible–changes, which left open many of the reform “pathways”.

A promising first step of the next government was to introduce a long-awaited substantial pay rise for the health care workforce.[59] The fall of 2002 saw structural reform enter the phase of policy formulation. The government suspended some of the restrictions on the privatization of delivery organizations[60] and replaced the existing law with a new one,

---

[56] Capacity norms are abolished, inclusion of new capacities to be approved by the Minister of Health, local governments are allowed more flexibility to restructure and reduce capacities: Act XXXIV of 2001 on the Territorial Supply Obligation of Specialist Health Services, further more on the Amendment of Various Laws in Connection with Health Care (promulgated: 12/06/2001) and Government Decree No. 77/2001. (V. 9.) Korm. on the Amendment of Government Decree No. 217/1997. (XII. 1.) Korm.

[57] Resolution No. 1066/2001. (VII. 10.) Korm. of the Government on the Principles of the Healthy Nation Public Health Programme, 2001-2010.

[58] Act CVII of 2001 on Provision of Publicly Funded Health Care Services and on the Forms of Practising Medicine (promulgated: 24/12/2001)

[59] Act XXIII of 2002 on the Amendment of Act CXXXIII of 2000 on the 2001 and 2002 Budget of the Republic of Hungary (promulgated: 19/7/2002)

[60] Government Decree No. 163/2002. (VII. 26.) Korm. on the Amendment of Certain Government Decrees on the Implementation of the Provisions of Act CVII of 2001 on the Provision of Publicly Funded Health Care Services and on the Forms of Practising

which provided a wider scope for the inclusion of private investment into the health care system.[61] To support the change in the ownership of health care facilities the government even offered subsidized loans for employee groups to privatize public providers.[62] Nevertheless, the impact of the new privatization regulation on the delivery system could not unfold, as it was later annulled by the Constitutional Court (Gaal 2004).

5.3.3. Direction of Change in the Health Care System and Searching Ways for the Future: 2002 and Onwards

Since 2002, health planning and prevention have been given more emphasis. The National Assembly accepted the Johan Béla National Programme for the Decade of Health, which set targets to improve the health status of the population through public health actions.[63] In the frame of this public health program, Hungary has launched national screening program for breast and cervical cancer and will introduce screening for colorectal cancer in 2006. In addition, the government encouraged regional health planning through the formation of the so-

---

Medicine; suspends the implementation of government decrees No. 116/2002, 69/2002 and 58/2002 till the 1 March 2003 in accordance with Act XXIII of 2002.

[61] Act XLIII of 2003 on Health Care Providers and on the Organization of Publicly Funded Health Care Services (promulgated: 30/6/2003) as a less restrictive regulation on the privatization of hospitals and polyclinics.

[62]Government Decree No. 184/2003. (XI. 5.) Korm. on the Health Care Investment Loan Programme and on the conditions of Bank Guarantees Provides subsidized loans for the privatization of health care facilities.

[63] Ten-year national public health programme: Resolution No. 46/2003. (IV. 16.) OGY of the National Assembly on the Johan Béla National Programme for the Decade of Health launching national screening programs for breast cancer and cervical cancer, from 2005 also for colorectal cancer.

called Regional Health Councils, and the elaboration of Regional Health Plans.[64]

In the second quarter of 2007, there was an intense debate between the governing parties regarding the restructuring of the health insurance system. They completely agreed that the single insurance system had to be transformed by fully preserving solidarity and a national risk pool. There was also agreement that the private sector should play some role in the reconstruction. The Socialist Party conceived this on the basis of regional managed care where the role of private capital is secondary, whereas the Free Democrats wanted a multi-insurance system within the social insurance scheme, where competing private insurers are granted a prominent role. By the end of July the two coalition partners made an agreement: switching to the multi-insurance system will commence in 2008. In the new model the newly formed 5-8 insurance companies in which private insurers may share ownership up to 49% will receive resources from the Health Insurance Fund. (Hungarian Health System Scan, June 2007: 1).

The larger coalition partner, the Socialists, conceived of decentralization on a territorial basis tied to administrative regions, and wished to assign the role of the private sector primarily to the side of service provision. The Free Democrats have been thinking in terms of insurance companies that compete nationwide, and conceived of competition among 100% public and 100% private insurers. As a result of political

---

[64] Call for proposals of the Ministry of Health, Social and Family Affairs for the Establishment of Regional Health Councils and for the Elaboration of Regional Health Care Development Plans (Health Gazette 2003/22, 10/6/2003). It provides financial assistance to set up Regional Health Councils and Regional Health Care Development Plans on a voluntary basis within the framework of the statistical-planning regions of Hungary

debates a model was created in which management funds compete with one another, where ownership is 51% public and 49% private. The act[65] passed in February 2008 by the Parliament with the votes of the governing parties.

However, the larger opposition party was against allowing private capital into the social insurance. It is the possibility of minority share private ownership in the Health Insurance Management Funds that has been attacked most in the act by the opposition. The political debate arising from this led to the acquittal of the Free Democrat Minister of Health by The Prime Minister, which evoked the rejection of the coalition partner, which announced breaking of the coalition contract. The Hungarian Socialist Party is preparing for minority governance. The party announced that they plan the reconstruction of health insurance by creating 7 regional health management funds in which no private capital can take part. This proposal for solution did not bring political peace (Hungarian Health System Scan, April 2008: 1).

The Government drafted the main health care tasks till 2010 in the Security and Partnership Program. In order to improve quality of care and the health status of the population this program contains measures relating to health promotion, the reform of provider system, the reform of health insurance system and the development of human resources. The major health programs (the Public Health Program and programs for cardiovascular diseases, cancer, youth health, emergency care) will continue and be strengthened. The central authority of the NHIFA (National Health Insurance Fund Administration) deals with the system-

[65] Act No I of 2008 on Health Insurance Management Funds

level tasks, especially inclusion of health technologies into social insurance reimbursement, and dealing with international cooperative and financial/accounting tasks, managing international accounting, issuing certifications (EU health card).

Decision 109/2008 (Sept. 26.) of the Constitutional Court has a special importance in terms of democratic issues. The Constitutional Court annulled several provisions of Act CXXXII of 2006 on the development of the health care system, as well as the decree n°54/2006 (Dec.29) of the minister of health, relating to the redistribution of specialized care capacities and the rules of access to specialized care. According to Act CXXXII of 2006: the minister made a proposition on the regional redistribution of capacities whereon the Regional Health Councils (RHCs) gave their opinion. The decisions of the RHCs were valid only in case they were approved by the sustainer (owner) of all the state financed inpatient health care providers of the region. Final decision in the issue was taken by the minister. The Constitutional Court established that the order of procedures laid down by the above reform law and created for the redistribution of specialized inpatient care capacities did not meet the requirements of democracy. In connection with the decisions of the Regional Health Councils the Constitutional Court stated that the regulation had trespassed the principle of democracy as the certification of the validity of the RHC decisions required approval from bodies (persons) that lacked democratic legitimation to exercise public authority(Hungarian Health System Scan, January 2009: 6).

In January 2008, the government attempted to privatize insurance companies again, however, Socialist and Liberal fractions in the government were not able to reach a consensus over the reform. The

coalition government of Ferenc Gyurcsány in Hungary fell due to protests of dissatisfaction with the reform of the health care sector, seen widely as unsuccessful. Besides, it was not clear to many what the competition between insurance companies will look like when the state would control majority of shares (Holub 2008).

In the international context the Hungarian healthcare system has been evaluated by two international organizations: the Health Consumer Powerhouse and the OECD. The Euro Health Consumer Index 2008 (EHCI) made by the Health Consumer Powerhouse is the annual ranking of national European healthcare systems from the point of view of consumers and covers 31 countries in 2008. The EHCI groups 34 quality indicators into six categories: Patient rights and information, e-Health, Waiting time for treatment, Outcomes, Range and reach of services provided, Pharmaceuticals.

The OECD study, Reforms for Stability and Sustainable Growth: An OECD Perspective on Hungary looks at ongoing efforts of Hungary to promote sustainable growth to accelerate the convergence process to EU criteria. It proposes structural reforms to achieve these objectives. The other OECD study entitled, Health Status Determinants: Lifestyle, Environment, Health Care Resources and Efficiency" examines the impact of healthcare and other determinants on the health status of the population and attempts to provide evidence on whether healthcare resources are producing similar value for money across OECD countries.

CHAPTER VI

THE CZECH REPUBLIC: AN ANALYTICAL APPROACH TO THE TRANSITION PROCESSES OF THE HEALTH CARE SYSTEM

In this chapter, the thesis examines the transition process of the health care system of the Czech Republic based on the main reform efforts in the health care system. The aim of this chapter is to identify the domestic health care policy preferences and the main drivers of the reform efforts in the Czech Republic. In this context, the thesis will try to explore the impacts of Europeanization and the arguments of New Institutionalism on the changes in the health care systems, especially in the health care policy-making processes of the Czech Republic.

In the first part of this chapter, the main reasons and drivers of the health care reform will be identified first to show that whether the transition of the health care systems of the Czech Republic was unavoidable under those circumstances. Second, the main actors in health care policy-making process which initiates the radical reform attempts in the country will be identified. In the third part of this section, the thesis will identify the main healthcare reform efforts based on the identifier transition attempts and governmental periods and the main health related laws and regulations will be given place.

6.1. Rationales of Transition of Health Care Systems of Czech Republic

In the Czech Republic, the system proved reasonably effective in dealing with the post-war problems of the early 1950s. During that time, a high infant mortality rate, tuberculosis, other serious infections and malnutrition diminished rapidly. By the beginning of the 1960s, Czechoslovakia had very good health status in international terms. From the late 1960s, these positive trends reached a turning point. Such a centralist and, in many cases, rigid system was not able to respond flexibly to new health problems caused mainly by the lifestyle of the population and by the environment. Thus, both the health care system and health status indicators stagnated from the late 1960s to the late 1980s (Rokosova et. al. 2005: 12). As consequences, coupled with severe economic crisis it raised as a necessity to implement radical reforms in field of health care sector.

By looking at the initial phase of health care reform in both countries, this analysis shows that the insustainability of the existing system and economic crisis is the main stimulator of the reform process in the health care systems, which strengthens the new institutionalists' 'critical junctures' perspective.

6.2. The Actors in the Health Care Policy-Making Process

In the case of the Czech Republic, republican-level ministries controlled the health care system in transition process. However, all health ministers have been doctors and Czech Medical Association has been a very active player in making health care policy. Thus, medical profession was very important pressure group in the constructing reform

plans and transition process of health care system of the country. In this respect, the most important group over the course of health policy was doctors and in a less extent pharmaceutical companies. The trade union, the Chamber of Doctors, was the driving force behind the policy changes of the early 1990s. In addition, hospitals and insurance companies also have had an important influence in the policy-making process of the health care sector in the Czech Republic. With the privatization efforts in the health care sector, hospitals have provided competitive pressures on costs and decentralization in the health care system. Their activities have enforced the Social Democratic Party government to increase wages, particularly in specialist hospitals. Lastly, as new players, the insurance companies in the Czech Republic had some influence on the health care policy making process. At the beginning, the system was quite liberal and there was no upper limit to reimbursements. The Czech General Health Insurance Fund began with 97% of the market in 1992 and the number of companies was 26 in 1994. However it was bankrupt within five months and the number of companies was 9 in 1999. Many of these privatized insurance companies had severe financial problems and had to be taken over by the government-run health insurance fund, which makes privatization effort unsuccessful. The Fund was re-launched with a bailout plan and consolidations. Pursuing a cost containment policy, the Czech General Health Insurance Fund ended up with a dominant market-share position. But the government left the least profitable 70% of clients and reimbursed only 60% of the total funds, removing its competitive pressure in a significant degree (Lawson and Nemec, 2003).

Privatization efforts in the health care sector involved a different motivation for different actors in the policy-making process. For the Czech government, the health care sector was oversupplied and

inefficient. Moreover, to repair the system there was a need for quite amount of capital, which was very difficult to find under the severe economic crisis that caused the collapse of the existing system. Thus, the motivation was to move these facilities out of the government's budget without clear conceptualization of privatization. The motivation among physicians for private practice or the privatization of practice was that of higher incomes and clinical autonomy. Physicians and dentists would no longer have to be state employees. They would be able to practice independently and receive fees from the government-run health insurance system or from patients directly (Scheffier, R. M. 1999: 4).

6.3. Transition of Health Care System of the Czech Republic in Stages

In this chapter, the thesis examines the transition process of the health care systems of the Czech Republic by each reform based on the time periods. The aim of this chapter is to identify the domestic health care policy preferences and the main drivers of the reform efforts. In this context, the thesis will try to explore the impacts of Europeanization on the changes in the health care systems, especially in the health care policy-making processes of the Czech Republic, if there is any.

6.3.1. Establishment of the Compulsory Social Insurance Model and Decentralization in the Health Care System: 1988-1994

Under the reform plan, all Czech citizens are covered by national health insurance. Health insurance funds are set aside by the government for health care. Following the German model, the Czech government

permits other health insurance funds to be established in the private sector.

In 1989, a humanization and democratization of the health care system, as well as the separation of the financing of health care from the state budget were considered to be the important issues. This was resolved by the introduction of single-source financing of health care through the introduction of statutory health insurance. In 1990 the Czech parliament adopted its “New system of health care in the Czech Republic”. The main characteristics of this new system can be listed as follows; community participation; guarantees of access to health care for all; the ending of the State monopoly on health-care provision; the establishment of compulsory insurance; allowing people to “top up” compulsory insurance with voluntary insurance; allowing private enterprise to make a contribution to the purchase and provision of health care; taking a more holistic approach to health care with better integration of the primary-care sector into the new system (Earl-Sater, 1996: 15).

In 1990 and 1991, in the midst of the democratization process, a dramatic liberalization of the health care system took place. In 1992, fundamental reform was initiated beginning with a 13.5% tax on gross wages to fund the new compulsory health insurance system. The established system was an employer-mandated system in which employers were required to pay two thirds and the employee the remaining one third. (Twaddle, 2002: 127). The principle of free choice of health care facility was introduced. The huge regional and district health authorities were dismantled. In 1991, new laws were approved especially the General Health Insurance Act (No. 550/1991 Coll.) and the Act on the General Health Insurance Fund (No. 551/1991 Coll.).

Since then, the health care system has moved towards a compulsory health insurance model, with a number of insurers financing health care providers on the basis of contracts. A complete reconstruction of the health care facilities and authorities has been achieved and a health insurance system has been created. A Medical Chamber, a Stomatological (Dentists') Chamber and a Pharmacists' Chamber were established and there was a re-emergence of medical professional societies and associations of societies of nurses and other health care professionals. A new system of home care has been established. At the same time, there was an almost complete privatization of primary health care, the pharmaceutical industry, pharmacies, health care support firms, spa facilities, etc.

In 1992 health-care financing was fundamentally reformed. The major strand of the reform is the compulsory health insurance model. The Czech Republic's General Health Care Insurance Office (GHIO) was the first established health insurance company. It was set up in 1992 as an independent insurance body to replace the former nationalized health care system, redistribute the money that came from the mandatory insurance system. The GHIO is required by law to accept anyone who applies to join the insurance group and is guaranteed by the government There is a second form of insurance in the Republic: branch insurance companies (BIC) (Earl-Sater, 1996: 16) There were up to 27 health insurance funds at one period in the mid-1990s; at the beginning of 2000, the number had decreased to nine.

Privatization is considered by some authors as a decentralization strategy (Atun, 2007: 246; Mills et al. 1990). In the Czech Republic, liberalization opened the door to a rapid introduction of a new system of health care financing and to the start of privatization. An initial step in

the hospital privatization effort was the decentralization of state-owned institutions. The state health plan called for the partial or total privatization of 83% of all state-owned institutions (Vyborna, 1994). Between 1990 and 1992, both the district institutes of national health and regional institutes of national health were dissolved and health care facilities obtained a high degree of legal and economic autonomy, however, neither the legislative nor the financial powers of these offices have been clearly defined. The district health officers are under the direct supervision not of the Ministry of Health, but of the Ministry of Interior Affairs, while the Ministry of Health provides methodological guidance and supervision (Health Systems in Transition: Czech Republic, 2000: 12).

Oswald summarizes the main outcomes of the privatization efforts in the health care sector of the Czech Republic as follows; the first outcome is a shift to economic priorities and vulnerable group in the public, especially elderly retired people, cannot access adequate health care services since in the health care sector pure economic issues were emphasized. Second outcome is the lack of sufficient cost controls and inadequate infrastructure to monitor utilization of health services. Third, the previous excess capacity in the health care employment level in the Czech Republic remained constant. In this context, over employment of the health care professionals, as it was prior to the fall of the communism have remained constant. Consequently, as the author specified, 'the efficiencies expected to be gained through the early privatization of the hospitals have not come to fruition.'(2000: 242). The fourth outcome is the inappropriate reimbursement schedule which makes the new system unsuccessful in achieving the cost control. The fifth outcome has a special attention in evaluating the privatization process of the health care system in the Czech Republic. The World

Bank (1993) recommended the private financing of health insurance and the expansion of the private delivery sector in response to the need for health care reform in formerly socialist countries including the Czech Republic. In this respect, although the Czech government followed this recommendation in theory, the insurance system was, in practice, flawed. The GHIO remains the only insurance company that consistently pays both physicians and hospitals and became a monopoly in health insurance sector. The sixth outcome is the no replacement of the outdated health care facilities and equipment because of the budget deficits. The next outcome is the constant problems in the physician payments, and another one is the increasing disparity in quality and availability of health care services. The ninth outcome of the privatization efforts in the Czech Republic is the strained social programs. The recent economic problems have put pressures on social programs and as a result the GHIO became responsible for the increasing number of clients who are unable to pay premiums. The tenth and the last outcome is the lack of consistency in national health care policies. Since the beginning of the privatization efforts in the health care sector, the reins of the highest ranking health official in the country have changed five times which confirms that there had been no continuity in the office of the Ministry of Health. The repeated change in this office, due partially to political shifts, has led to contradictions in the approach to health care transformation (Oswald, 2000: 240-47).

Without question the motivation for the privatization of the Czech health care system was to transfer the centralized power of the state-run health care system to private individuals and institutions. This motivation was the same one that was driving the privatization of the Czech economy overall. According to Scheffler, the noteworthy point is that a key part of the social support system, the health care, was

privatized so rapidly and without a clear idea of the role of the private sector (Scheffier, 1999: 3).

Warren (1984: 29) suggests “the privatization of healthcare and social institutions denies access to care, creates socially stratified care accompanied by declining quality, and threatens public safety.” (1984: 29).

Improvements which have been experienced especially in this period provide strong evidence that implicate all the reform efforts in the Czech Republic as well as Hungary. Because they tend to establish Bismarckian health systems, historical legacy and path dependency are better in explaining the transition process of the health care system in these countries as opposed to Europeanization concept.

6.3.2. Cost Containment Objective in the Health Care System: 1995-2002

Partial changes responded to the most problematic areas of needs of the Czech health care system including its financing. However, they did not bring any major change to the financial situation of the statutory health insurance.

Since 1993, overall health care expenditures have risen to a respectable amount. Particularly the proportion of health insurance

funds in the total health care expenditures has risen from 76% in 1993, to 81% in 1998, and to 89,4%[66] in 2006.[67]

The rapidly rising costs were one of the most visible and predictable effects of the reform. It caused a pressure on budget and new efforts were needed to control huge deficits. As it is stated in the World Bank Country Study on the Czech Republic, 'a series of amendments to the original legislation effectively undermined elements of the reform'.[68]

As a consequence, in 1995 newly established insurance companies began to bankrupt and there were only 9 insurance companies by 1998. The main problem was inadequate regulation of health insurance system. The introduction of fee for service in the financing side of the health care system caused new problems; bills of the health services exceed the fixed revenues of the health insurance companies. Moreover, restrictions on the actions of insurance companies reduced their flexibility, increasing the existing problems.[69]

In this period, some measures taken by the government was seen as a return to the pre-1990 era. The Ministries of Interior and Defense established their own health insurance companies to serve their employees. In addition, the Ministry of Health institutes other restrictions on health insurance companies. Consequently, 'competition was not permitted on benefits or price, and the disintegration of the competitive

[66] A World Bank Country Study, Czech Republic Toward EU Eccession, The World Bank, Washington DC, 1999,p. 221

[67]WHOSIS http://apps.who.int/whosis/data/Search.jsp

[68] A World Bank Country Study, Czech Republic Toward EU Eccession, The World Bank, Washington DC, 1999,p. 222

[69] Ibıd. 223

insurance market effectively undermined the concept of a market-driven reform'.[70]

Another key piece of legislation making provision with respect to the health care system, namely the act entitled Care for the People's Health (No. 20/1966 Coll.), was amended several times during the period of 1998-2002. In April 2001 the Government presented a health care bill and a bill concerning health care facilities and their operation. However, in December 2001 the Chamber of Deputies dismissed these bills in the first reading.

After the 1998 election the Czech Social Democratic Party formed a minority government. The election platform of this political party, called "Together for a Better Future", saw health as "a public property, source of the society's wealth and good living conditions and not just private property and goods". Any limitation of the principle of solidarity with citizens having low incomes, and with ill and elderly people, was unacceptable. The system of payments to health care providers was to include incentives to enhance effectiveness and maintain a high quality of care at the same time. These principles were later reflected in The Government's Policy Statement (1998) and Health Care Concept (March 1999). Towards the end of 1999, internal problems at the Ministry of Health came to a head; in addition, they were accompanied by difficulties with which the Minister of Health had to deal on behalf of the Czech parliament. In response to this political pressure the Prime Minister relieved him of his functions.

[70] Ibıd. 224

At the beginning of the second half of the 1990s, these problems suggested the need for new regulatory mechanisms following the period of rapid liberalization. There had been a gap between the development of Czech health care reform and the beginning of regulation of this newly adopted and implef2mented system, particularly in the field of health care financing. It took almost five years to have an effect: simple fee-for-service payments in primary health care were combined with capitation fees, a new mode of payment for hospitals was introduced and the fee-for-service payments were modified for ambulatory specialists. Act No. 48/1997 Coll., which enabled these changes, was originally limited to two years but this limitation was twice prolonged and finally cancelled by Act No. 459/2000 Coll., i.e. the 1997 law remains in force.

In 2000 the Government of the Czech Republic adopted a National Quality Policy in the form of Decree No. 458. This defined a package of methods designed to improve quality of products, services and activities. The main objectives of the decree included: the development of a national accreditation system; assurance of quality in public services; standardization; staff training and retraining; and creating a system of quality assurance. In the same year the Ministry of Health founded the Czech Republic Quality Council to coordinate the health-related elements of the National Quality Policy (Legido-Quigley, 1008: 97).

In June 2000, the Ministry of Health submitted, to the government, proposed amendments to the Statutory Health Insurance Act (No. 48/1997 Coll.), the Department, Field, Company, and Other Health Insurance Funds Act (No. 280/1992 Coll.), the General Health Insurance Fund Act (No. 551/1991 Coll.) and the General Health

Insurance Contribution Act (No. 592/1992 Coll.). These amendments were aimed at making changes leading to the elimination of the shortcomings of the existing acts by aligning them with the Czech Social Democratic Party mission statement. However, for various reasons, the amendments were never passed and the Minister of Health withdrew the government proposal from being discussed in the Chamber of Deputies of the Czech parliament.

In 2000, the Ministry of Health also set up a Centre for International Reimbursements of Health Care Services provided in connection with the free movement of persons in the EU. The web pages of the centre offer important information both for the citizens of other countries and for Czech citizens. The web site publishes documents related to the provision of health care in other EU countries (regulations 1408/71 and 574/72, rulings of the Court of Justice, international agreements on social security and a list of agreements on the provision of health care).

Some legislative changes took place in relation to the accession of the Czech Republic to the EU, in particular, Act No. 123/2000 Coll. was adopted, which makes provision with respect to medical devices, together with Act No. 407/2001 Coll., amending the Addictive Substances Act and the Protection of Public Health Act (No. 258/2000 Coll.). In addition, the Transplantation Act (No. 285/2002 Coll.) has also to be mentioned, as it is achieving urgently needed regulation of transplantation medicine by the Ministry of Health (Rosenmöller, 2005).

6.3.3. Direction of Change in the Health Care Systems and Searching Ways for the Future: 2002 and Onwards

In this period, transfer of half of the state-owned hospitals to 14 newly formed, self-governing regions can be seen as an important development in the continuum decentralization efforts in the health care system of the country.

Two statutes enacted in 2004 are important for the harmonization of Czech legal norms with respect to the country's accession to the EU. The following statutes set out the rules for the acquisition and recognition of professional qualifications in health care occupations: Act no. 95/2004 Coll., on the conditions for acquiring and recognizing qualifications for the performance of the medical occupations of physician, dentist, and pharmacist; and Act No. 96/2004 Coll., on the conditions for acquiring and recognizing qualifications for the performance of non-medical occupations in health care and for the execution of activities related to the provision of health care and on changing certain related acts (Act on Non-medical Occupations in Health Care). The preparation and discussion of these two statutes took more than four years. Aside from a government draft, there was a version put forward by members of the parliament. Both drafts had a number of problems and questionable goals. Disputes arose due to the different interests of the various health care occupations, which in the end led to the adoption of two acts, one for medical occupations and pharmacists, and one for non-medical occupations.

Following the Biennial Collaborative Agreement between the Czech Republic and the WHO Regional Office for Europe, a Review of Health Promotion Policy and Infrastructures in the Czech Republic was conducted in 2002–2004. Its results were a critical reflection of the country's development and offer options which could be used for designing and implementing health promotion policy in the future. The

Review of Health Promotion Policy and Infrastructures in the Czech Republic formulated a number of stimulating suggestions as to the further development of health promotion policy.

In the transition process, the establishment of a central health insurance administration, to supervise the present nine health insurance funds and control their activities, was planned. Because of its electoral failure in elections for the European Parliament, the government resigned in mid-2004. Just after her appointment in August 2004, the new Minister of Health, Milada Emmerová, presented a policy document for the period 2005–2009 for the purpose of society-wide discussion. The concept was, once comments had been incorporated, presented to the government for discussion on 1 February 2005. The concept addresses the problems of the financial deficits of the statutory health insurance, presents a proposal for the creation of regional public health care service plans and for improving the efficiency of public administration in statutory health insurance, and proposes a new system for dealing with patients' complaints. The smaller sickness funds are trying to prevent those changes, as they fear that the system of multiple health insurance funds may be abolished. The government plans to enact a statute on health care institutions which would set the rules for the creation of public health care service plans. The aim of that statute is to optimize the structure of public health care services and to address the problems of their excess or inadequacy in various regions and in the city of Prague. Other measures focus on the application of tools aimed at the stability of the financial management of hospitals and sickness funds.

The main reform efforts in the Czech health care system since 2005 can be listed as follows: The implementation between 2005 and 2006 of a new risk-adjustment scheme for redistributing SHI contributions

among the health insurance funds; The introduction in 2008 of (a) user fees for doctor visits, hospital stays, prescription pharmaceuticals and the use of ambulatory services outside of regular office hours; The inclusion in 2008 of the State Institute for Drug Control in the process of setting maximum prices and reimbursement rates for pharmaceuticals; The introduction in 2008 of a program to supply accredited providers with additional financial support for training physicians in medical specialties and specialized nurses; An initiative to improve the quality of highly specialized care by identifying high-performing health care facilities and allowing for special contractual conditions between these facilities and the health insurance funds (Bryndova et al., 2009: 18). Additionally, in 2008, the number of health insurance funds became ten with the establishment of a new one.

According to Hrobon (2008), the government has created a proposal for fundamental reforms within the health care sector based on the market, rather than the government which is planned more effectively increase the efficiency of the system and the comfort of the policyholders. The government therefore proposed a regulated competitive market for insurance companies and the offers that they make to clients. The reform plans, even before its implementation has met reaction and rejection from the opposite parties. The reason of this opposition is sees based incomplete explanation of the reforms aims. Other factors also include: an unfavorable economic and political environment, the impact (mostly emotional) of the insufficient economic reforms in the 1990s, and even a deeper emotional fear of a market-driven health care system. An unstable government and the constant fighting between the two main parties in the country do not make for a favorable environment for any kind of reforms (Hrobon, 2008: 15).

In the Czech Republic, many of the health care reforms attempted to overcome financial instability and chronic deficit in the SHI system. Most of the reform efforts are related providing financial stability in the health care system, even the issue of hospital ownership and management structures. There were some efforts which have focused on improving purchaser-provider relationship and compliance with EU law. Access to high-quality health care based on the principle of genuine solidarity, strengthening patient rights and bringing these into compliance with present-day social needs and the Czech Republic's commitments to the EU are the main areas on the agenda and will be the key determinants of the direction of the health care reform in the Czech Republic.

CHAPTER VII

CONCLUSIONS

The present study shows that the health care reforms in Hungary began in the last years of the communist regime. Also, the Czech Republic health care system started to transform after the collapse of the communist regime. That is to say, after the collapse of the communist bloc, a democratization process began in the communist countries. With the change of the regime and the governments, a dramatic change involving a liberalization process began in the health care systems.

Regarding the questions asked in the Introduction, this study shows that the explanatory power of Europeanization is not as powerful in explaining the changes associated with the transition process in the health care systems of Hungary and the Czech Republic as many studies suggest.

In the first place, the lack of a general theory or a clear definition of the concept which makes Europeanization ambiguous deserves to be explored. This is largely reflected in the literature over the definition and mechanisms of Europeanization which makes it difficult to test the empirical validity of the hypothesis.

Taking into consideration the three main distinctive theories related to the Europeanization concept, first of all, there is a lack of any connection between the 'domestic Europeanization' and the transition of

the health care systems of case countries, because there is not any distinct EU model, i.e. a clearly defined EU-level health policy as health policy is not among the 'common policies' of the European Union. Similarly, the literature that focuses on anthropological variables is also weak in explaining the changes in the health care systems of the Czech Republic and Hungary, since it is more interested in the emergence of a homogenous European culture and identity. Lastly, 'normative Europeanization' deserved more attention as it puts emphasis on democratization and opening the economy.

Then the study asks the second main question to learn how such a transition process could be characterized. Would the implementation of the Social Health Insurance (SHI) system in CEECs imply a path dependency in the transition processes of health care systems in Hungary and the Czech Republic? In contrast to the insights of these approaches in the literature, the main findings in the present study suggest instead that transition of the health care systems of Hungary and the Czech Republic were an inevitable consequence of the severe economic crisis before any other factors. In addition, as an answer to the second research question, the study analyzed the historical background of the health care systems of case countries, and shows they have the roots of the Bismarckian health system in their histories. In the transition process of health care systems of these countries, it was taken as a positive experience while the Beveridgean health system serves as a negative experience since it resembles a centralist system in terms of tax-based health care expenditures. At this point, this study implies that the transition in health care systems of these countries is path dependent since they chose to implement a Bismarckian model even after a half century. The study looked at the initial condition of the health care systems of Hungary and the Czech

Republic in the 1990's. Changes in the health care systems in the Czech Republic and Hungary had emerged before the beginning of "pre-accession" negotiations with the European Commission in 1998. Moreover, it seems that the health care system reforms of Hungary were largely a product of the 1970s and 1980s, well before the collapse of communism. According to the findings, the main stimulator of the health care systems' transition in these countries is their inability to sustain their old systems because of the severe economic crisis they faced having had systems financed through taxes and state budgets.

Although, the changes in the health care systems of these countries started previous to negotiations with the EU, in the process of transition, it seems that these health care systems were affected directly or indirectly by the European Union in many ways, especially when taking into consideration the motivations of domestic political actors. However, through analyzing the direction of change of the health care systems of Hungary and the Czech Republic, this study found out that, the indicators related to the health status, financial resources and health expenditures of the cases are still below the EU average, although there have been some advances compared to the past. In general, the main health indicators of the Czech Republic and Hungary point to a lack of strong effect of Europeanization in terms of the consequences of the health care systems in transition.

The analysis in the annex concerning the health indicators of the Czech Republic and Hungary as compared to that of the EU-15 shows the following:

- In the year 2006 (which is latest year in which comparable data is available) while per capita total expenditure on health at average

exchange rate remains at USD 943 in the Czech Republic and USD 853 in Hungary, where the EU average is USD 3,610, which is 3,8 and 4,2 times higher than the cases analyzed, respectively.

- In the same year, public expenditure as a percentage of total expenditure on health is 87,9% in the Czech Republic and 70,8% in Hungary. This indicator is not markedly different from that of the EU-15, which is 76,7% on average. The EU countries which implement the Bismarckian health system (Belgium, France, Germany, Luxemburg and Netherlands) this indicator is 80% on average. However, when we look into the political and structural side of the financing mechanism, the scene is somewhat different. According to the literature, while the Bismarckian system is characterized by multiple insurance funds competing with each other, which is its main difference from the Beveridge system, we observe a single national health insurance fund in Hungary. Financing of current expenditure and purchasing functions is delegated to this single National Health Insurance Fund and the Fund is governed by tight central control. Consequently, the national government is still the key regulator of the system and health expenditures, actually, are made according to the budget without competition.

- For the case of Hungary, after the transition process in the Hungarian health care system, the health indicators could not reach the average of the EU countries. As an example, as one of the most important indicators, life expectancy at birth remains below the EU average. While the life expectancy of male citizens of Hungary at birth is 61 years, this remains far below the lowest

figure for the EU members in the EU-15 in any given period. In parallel to the male citizens' life expectancy at birth, the female citizens' life expectancy at birth is lower than the average for the EU-15. Moreover, according to these findings, it is clear that the health expenditures of Hungary are below the average of EU after the transition process. So it could be said that the transition process was not enough reform the Hungarian health care system so as to reach the EU standards. This can be called a failure in the transition process of Hungarian health care system. The main reason for the failure of the transition process is, in Hungary, health reforms have been hindered by "endemic conflict" among the Ministry of Health, the National Health Insurance Fund, and the Ministry of Finance, who have had "overlapping responsibilities in the financing, policy preparation and administration of healthcare" (Orosz and Burns, 2004: 43).

- The results of the transition process of the health care system in the Czech Republic are not different from those of Hungary. For example, after the transition process of the health care system of the Czech Republic, the life expectancy of the Czech citizens was lower than the lowest of the EU Citizens. Also when the health expenditures are examined, in the Czech Republic they are below the average of the EU. But when the health care systems of Hungary and the Czech Republic are compared, the health care transition process of the Czech Republic has better results than the Hungarian health care transition process. The main reason for this is that the Czech reforms have been substantial and have opened up a variety of insurance funds as opposed to the single fund in Hungary (Schimmelfenning and Sedelmeier, 2006).

Health care reforms both, in Hungary and the Czech Republic, share two important issues: (1) there are many interest associations present, and (2) the EU's very sparse health policy development provides the EU little leverage. This point constitutes one piece of evidence that Europeanization does not explain the changes. The lack of EU leverage means that the Hungarian and Czech politicians were free to take foreign advice only where they chose to. On the political side, despite the reform efforts in terms of decentralization in Hungary, this study demonstrated that there is not a continuous and stable reform attempt in the field of health care policy as it is seen in the case of other policies which are directly related to European Union membership and therefore necessitate the harmonization of laws.

Then, how can we explain the transition process in the health care system? First, the case studies above show that the health care reforms in Hungary and the Czech Republic were shaped by the economic circumstances in which these countries found themselves. Through this perspective, the main driver of the reform efforts in these countries is the state of the national economy in that they had been less and less able to sustain their health care systems financially. With severe economic crises and the collapsing of the communist system, these countries felt the need to reform their old systems whereby the trend has been away from universal access financed by taxes from the budget.

Secondly, the present study also suggests that the historical legacy of these countries affected the way their health care systems developed after the collapse of communism. Hungary and the Czech Republic, as cases in which health care policies were strongly influenced by the

political tradition of the Austro-Hungarian Empire, have the roots of the social health insurance system in their historical legacies.

Thirdly, in addition to the above domestic variables, international factors other than the EU come into play in explaining the changes in the health care systems. The above discussion of the case studies shows that international organizations, primarily the International Monetary Fund and the World Bank, as the major lenders of conditionality-based development aid and supporters of market-oriented finance and delivery in health care systems, influenced the transition process of our case health care systems. We see considerable reform efforts to decentralize and privatize the health care systems in Hungary and the Czech Republic. However, in both cases, these reform efforts have met fierce opposition both from opposition political parties and trade unions.

Despite these radical reform efforts to the health care system, in Hungary, the government abolished the self-governance of the HIF altogether making a considerable step towards its recentralization. Although privatization is seen as an important reform in the transition process of the health care system, service delivery by private providers is still limited, since family doctors have been encouraged to become private and contract with the local government for the provision of primary care services, with surgeries and equipment still owned by the local government; this became known as the scheme of "functional privatization". In addition, many efforts which allowed private capital into social insurance so as to create competition between insurance funds resulted in failure. All these indicators strengthen the point that the historical legacy and political economic culture of the country must be considered. Therefore, the state of the national economy comes into the scene again. In terms of economic crisis, the health sector was seen as

a potential threat to fiscal balances and reform was framed as inevitable. So, in order to control the runaway health care expenditures, the government took over the administration of The Health Insurance Fund from the National Health Insurance Fund Administration and revenue of the Fund started to be collected by the National Tax Office thereby reflecting continued governmental control.

In the Czech Republic in 1990 and 1991, a dramatic liberalization of the previously centralized Semashko health care system took place. The system began moving towards a compulsory social health insurance model, with a number of insurers financing health care providers on the basis of contracts. The three main features of the health care system are compulsory health insurance, funded by contributions from individuals, employers and the state; diversity of provision, with mainly private ambulatory care providers and public hospitals having contractual arrangements with the insurance funds; and joint negotiations by key actors on coverage and reimbursement issues. However, the government supervises the negotiations and still has to approve the outcome.

Therefore, this thesis suggests that the health care reforms in Hungary and the Czech Republic were strongly influenced by the state of the national economy (and therefore the lack of resources forced difficult resolutions), their historical legacies, and external factors, particularly international organizations other than the EU exercising strong pressure on social spending in general and health care expenditures in particular. Thus, in order to better understand the major reforms of the health care systems in these cases, the thesis deemed it necessary to look back at the development of their social health insurance systems within the

context of their historical background and their economic circumstances during their transition period.

In conclusion, the transition processes in the health care systems of Hungary and the Czech Republic have certainly not come to an end. The dominant reform trends have been decentralization and liberalization of the health sectors which have not come to full fruition yet. In this regard, the historical legacies of the countries will continue to act as sources of institutional inertia. Furthermore, there is not a strong Europeanization effect as is generally claimed. However, any future reform will have to be adapted to meet the challenges of the European internal market since a quarter of all EU rules on completion of the single market are related to security and health.

REFERENCES

Agh, A. (2002) "The dual challenge and the reform of the Hungarian Socialist Party", *Communist and Post-Communist Studies*, Vol. 35 269–288, www.elsevier.com/locate/postcomstud (retrieved on September 10, 2009).

Atun, R. (2007) "Privatization as Decentralization Strategy", in Saltman, R., B., Bankauskaite, V., Vrangbaek,K. (eds.) *Decentralization in Health Care*, World Health Organization 2007 on behalf of the European Observatory on Health Systems and Policies, Glasgow: Bell & Bain Ltd.

Börzel, T. (1999) "Towards Convergence in Europe? Institutional Adaptation to Europeanization in German and Spain", *Journal of Common Market Studies*, Vol. 37, No. 4, pp. 573-596.

Börzel, T. and Risse, T. (2000) "When Europe Hits Home: Europeanization and Domestic Change", *European Integration Online Papers*, Vol. 4, No. 15

http://eiop.or.at/eiop/texte/2000-015a.htm (retrieved on November 20, 2009)

Börzel, T. (2002) "Pace-Setting, Foot-Dragging, and Fence-Sitting: Member State Responses to Europeanization", *Journal of Common Market Studies*, 40(2), 193-214

Börzel, T. and Risse, T. (2003) "Conceptualizing the Domestic Impact of Europe", in Featherstone, K. and Radaelli, C. (eds), *The Politics of Europeanization: Theory and Analysis,* Oxford: Oxford University Pres pp. 57-59.

Bryndová L, Pavloková K, Roubal T, Rokosová M, Gaskins M and van Ginneken E. (2009) "Czech Republic: Health system review", *Health Systems in Transition*, Copenhagen: European Observatory on Health Systems and Policies, 11(1), 1-122.

Bulmer, S., Burch, M. (2000) "The Europeanization of British Central Government", in Rhodes, R. A. W. (ed), *Transforming British Government-Vol 1, Changing Institutions*, Houndmills: Macmillan, pp. 46-62.

Busse, R., Wismar, M. and Berman, P. C. (eds) (2002) *The European Union and Health Services. The Impact of the Single European Market on Member States*. Amsterdam: IOS Press

Caporaso, J. (2007) 'The Three World of Regional Integration Theory', in Graziano, P. and Wink, M. P. (eds.), *Europeanization New Research Agendas,* New York: Palgrave Macmillan, pp. 23-34

Cerami, A. 2005, "Social Policy in Central and Eastern Europe. The Emergence of a New European Model of Solidarity?", paper to be presented at the Third Annual ESPAnet Conference '*Making Social Policy in the Postindustrial Age*', University of Fribourg, Switzerland, September 22-24, 2005

Cerami, A. (2006) "The Politics of Reforms in Bismarckian Welfare Systems: The Cases of Czech Republic, Hungary, Poland and Slovakia", paper presented at the conference '*A long good bye to Bismarck? The politics of welfare reforms in Continental Europe*', Minda de Gunzburg Center for European Studies, Harvard University, Cambridge, Massachussets June 16 - 17, 2006

Cerami, A. 2006b, "Europeanization, Enlargement and Social Policy in Central and Eastern Europe", paper presented at the *CONNEX PhD Workshop*, Sciences Po, Paris, May 30, 2006

Commission of the European Comminities. Comminication from the Commission to the Council, the European Parliament and the Economic and the Social Committee and the Committee of the Reagions on the development of public health policy in the European Community (COM (98)230). Luxemburg: Office for Official Publication of the European Communities, 1998

Coughlin, R.M. (2001) "Convergence Theories", in Borgatta, E.F., Borgatta, M.L. (eds.), *Encyclopedia of Sociology*. 2. ed.

Cuperus, R. and Kandel, J. (eds) (1998) *European Social Democracy. Transformation in Progress*, Amsterdam: Wiardi Beckman Stichting and Friedrich Ebert Stiftung.

Cucic, S. (2000) European Union Health Policy and its implications for national convergence, *International Journal for Quality in Health Care,* 2000; Vol. 12, No. 3, pp 217-225.

Deacon, B., Hulse, M. & Stubbs, P. (1997) *Global Social Policy. International Organizations and the Future of Welfare*, London: SAGE Publications.

Dezseri, K. (2007) "Three Years of the EU Membership-The Case of Hungary", ISPI Working Papers, WP-14 http://www.ispionline.it/it/documents/wp_14_2007.pdf (retrieved August 8, 2009).

Earl-Slater, A. (1996) "Health-care Reforms in the Czech Republic", *Journal of Management in Medicine*, Vol. 10, No. 2, 1996, pp. 13-22.

The Economist (2006) "*A sign that politics in central Europe may be maturing",* April 27, 2006

http://www.economist.com/world/europe/displaystory.cfm?story_id=E1_GRVVRSG&source=login_payBarrier (retrieved on September 15, 2009).

Efthimios D. Avgerinos, Sotirios A. Koupidis, Dimitrios K. Filippou, (2004) "Impact of the European Union enlargement on health professionals and health care systems", *Health Policy,* 69 (2004), pp. 403–408.

European Commission, *Social Protection in Europe*, Brussels: COM (1993) 531

European Commission (2000) 'Commission's Work Programme for 2000 and the Strategic Objectives for 2000–2005', Press release. Brussels: European Commission.

European Commission (2002) *Communication from the Commission*: *proposal for a joint report*: *Health care and care for the elderly: supporting national strategies for ensuring a high level of social protection*, COM (2002) 774 final of 3 January 2003.

European Commission (2003): *Communication from the Commission concerning the introduction of a European health insurance card*, COM (2003) 73 final of 17 February 2003

European Commission (2004), '*Communication from the Commission. Modernising Social Protection for the Development of High-quality, Accessible and Sustainable Health Care and Long-term Care: Support for the National Strategies Using the 'Open Method of Coordination'*, COM (2004) 304 final. Luxembourg: European Communities.

European Commission, *A Renewed Commitment to Social Europe: Reinforcing the Open Method of Coordination for Social Protection and Social Inclusion*, Brussels: COM (2008) 418, 2.7.2008.

Featherstone, K. (2003) “Introduction: In the name of Europe”, in Radaelli C. and Featherstone, K. (eds.), *The Politics of Europeanization: Theory and Analysis,* Oxford: Oxford University Press, p.3

Ferge, Z. & Juhász G. (2004) “Accession and social policy: the case of Hungary”, *Journal of European Social Policy*, Vol. 14, No. 3, 233-251.

Flockhart, T. (2007), *Europeanization and EU-ization*, Paper to be presented at the 6th Pan-European International Relations Conference Turin, 12- 15 September 2007.

Freeman, R. and Moran, M. (2000) “Reforming Health Care in Europe”, *West European Politics*, No. 23, 35–59.

Gaal, P. (2004) *Health Care Systems in Transition:Hungary*, Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Gaal, P. (2005) “ Benefits and entitlements in the Hungarian health care system”, *Eur J Health Econom* Suppl 1, No. 6, pp. 37-45

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1388083/pdf/10198_2005_Article_317.pdf (retrieved on October 24, 2009).

Graziano, P. (2003) ‘Europeanization or Globalization?: A Framework for Empirical Research (with Some Evidence from the Italian Case), *Global Social Policy*, Vol. 3, No. 2, pp. 173-194 http://gsp.sagepub.com/cgi/reprint/3/2/173 (retrieved on September 2, 2009).

Guillén, A. M. 2002. The Politics of Universalisation: Establishing National Health Services in Southern Europe. *West European Politics* 25: 49–68.

Guillén, A. M. And Álvarez, S. (2004) “The EU’s impact on the Spanish welfare state the role of cognitive Europeanization”, *Journal of European Social Policy*, Vol. 14, No. 3, pp. 285-299.

Guillén, A.M. and Palier, B. (2004) “Introduction: does Europe matter? Accession to EU and social policy developments in recent and new Member States”, *Journal of European Social Policy*, Vol. 14, No. 3, pp. 203-209.

Hacker, J. S. (2002) *The Divided Welfare State: the Battle over Public and Private Social Benefits in the United States.* Cambridge: Cambridge University Press.

Hall, P. A., and R. C. R. Taylor. 1996. Political Science and the Three New Institutionalisms. *Political Studies* 44: 936–957.

Health Care Systems in Transition:Czech Republic (2000), Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems.

Hix, S., *Goetz*, K., H. (*2000*) "Introduction: European integration and national political systems", *West European politics*, Vol. 23, No. 4, pp. 1-26.

Holmes, A. R. (2009) *The Third Way: Globalization's Legacy*, Leicester: Troubador Publishing Ltd. p.179

Holub, P. (2008) "Will Czech Health Reform Meet Fate Of Hungarian One?", *Aktualne.cz,* May 02, 2008 http://aktualne.centrum.cz/czechnews/clanek.phtml?id=604084 (retrieved on July 14, 2009).

Hrobon, P. (2008) "Why We Are Afraid of the health care market?", *Reform of Health Care*, Autumn, 2008, pp.15-17 http://media.web.britannica.com/ebsco/pdf/36/36095024.pdf (retrieved on July 12, 2009).

Hungarian Ministry of Health, the official web site is available at http://www.eum.hu/english/main-policy-objectives/reform-of-the-health (retrieved on August 2, 2009)

Hunter, D.J., Vienonen, M. and Wlodarczyk, W.C. (1998) Optimal balance of centralized and decentralized management. In Saltman, R.B., Figueras, J. and Sakellarides, C. (eds), *Critical challenges for health care reform in Europe*. Buckingham, Open University Press.

Immergut, E. (1992) *Health Politics, Interests and Institutions in Western Europe*. NewYork: Cambridge University Press.

Johnston, A.I. (2001) "Treating International Institutions as Social Environments", *International Studies Quarterly,* No. 45, 487-515.

Knill, C. (2001) *The Europeanization of National Administrations: Patterns of Institutional Change and Persistence,* Cambridge: Cambridge University Press,

Lawson, C. and Nemec, J. “The Political Economy of Slovak and Czech Health Policy: 1989-2000”, *International Political Science Review,* 2003, 24(2), pp. 219-235

Lear, J., and Mossialos, E. (2008) *EU Law and Health Policy in Europe*, The Health Policy Bulletin of the European Observatory on Health Systems and Policies, Vol. 10, No. 3, Autumn 2008, pp.1-3.

Legido-Quigley H., McKee M., Nolte E., A Glinos I. (2008) “Policies to promote quality of care in European Union Member States”, in *Assuring the Quality of Health Care in the European Union: A Case for Action,* European Observatory on Health Systems and Policies, Observatory Studies Series, No. 12., pp. 77-190.

Lendvai, N. (2004) “Review Essay: The weakest link? EU accession and enlargement: dialoguing EU and post-communist social policy”, *Journal of European Social Policy*, Vol. 14, No. 3, pp. 319-333.

Lendvai, N. (2005) “Remaking European Governance : Transition, Accession, Integration”, in J. Newman (ed). *Remaking Governance. Peoples, Politics and the Public Sphere*, Bristol: Policy Pres, pp. 59-81.

Mahoney, J. (2000) “Path Dependence in Historical Sociology”, *Theory and Society*, Vol. 29, No. 4, August 2000, pp. 507-548 http://links.jstor.org/sici?sici=03042421%28200008%2929%3A4%3C507%3APDIHS%3E2.0.CO%3B2-Z

Manning, N. 2004, “Diversity and change in pre-accession Central and Eastern Europe since 1989”, *Journal of European Social Policy*, vol. 14, no. 3, pp. 211-232.

Manning, N. (2006) “European Union Impact on Social Policy in New Member and Candidate Countries”, paper presented at the international conference ‘*Transformation of Social Policy in Europe: Patterns, Issues and Challenges for the EU-25 and Candidate Countries*’, Department of Political Science and Public Administration Middle East Technical University, Ankara, Turkey, April 13-15, 2006 http://www.ctspe.metu.edu.tr/papers/manning.pdf (retrieved on October 22, 2009)

Mechanic, D., Rochefort, D., A. (1996) “Comparative Medical Systems”, *Annual Review of Sociology,* Vol. 22, pp. 239-270

Mills, A., Vaughan, P.J., Smith, D.L. and Tabibzadeh, I. (eds) (1990) *Health system decentralization: concepts, issues and country experience*. Geneva, World Health Organization.

Mossialos, E. and Palm, W.,(2003) "The European Court of Justice and the free movement of patients in the European Union", *International Social Security Review*, Vol. 56, No. 2, 2003, pp.3-29.

Mossialos, E., and McKee, M. (2002) *EU Law and the Social Character of Health Care Systems*, Brussels: Peter Lang.

Müller, K. (1999) *The Political Economy of Pension Reform in Central-Eastern Europe*, Cheltenham, UK: Edward Elgar.

Müller, K. 2002, "Beyond privatization: pension reform in the Czech Republic and Slovenia", *Journal of European Social Policy*, vol. 12, no. 4, pp. 293-306.

Müller, K. 2004, "The Political Economy of Pension Reform in Central and Eastern Europe", in *Reforming Public Pensions. Sharing the Experiences of Transition and OECD Countries*, ed. OECD, OECD, Paris, pp. 23-50.

McBride, S. and Russel A.W. 2001, "Globalization, the restructuring of labour markets and policy convergence", *Journal of European Social Policy*, Vol. 1 No. *3*, pp. 282-309.

McKee, M., Mossialos, E. and Baeten, R. (eds) (2002) *The Impact of EU Law on Health Care Systems*. Brussels: Peter Lang. National Institute for Strategic Health Research: Hungarian Health System Scan (2007) January http://www.eski.hu/new3/hirlevel_en/2009/HungarianHealthSystemScan-2009-1.pdf (retrieved on July 20, 2009).

National Institute for Strategic Health Research: Hungarian Health System Scan (2007) June http://www.eski.hu/new3/hirlevel_en/2007/Hungarian%20health%20system%20scan2.pdf (retrieved on July 20, 2009).

National Institute for Strategic Health Research: Hungarian Health System Scan (2008), April 2008. www.eski.hu/new3/hirlevel_en/2008/HungarianHealthSystemScan-4.pdf (retrieved on July 21, 2009).

National Institute for Strategic Health Research: Hungarian Health System Scan (2008) May

www.eski.hu/new3/hirlevel_en/2008/HungarianHealthSystemScan-4.pdf (retrieved on July 21, 2009).

National Institute for Strategic Health Research: Hungarian Health System Scan (2009) January www.eski.hu/new3/hirlevel.../2009/HungarianHealthSystemScan-2009-1.pdf (retrieved on July 21, 2009).

Nunberg, B. (2000). *Ready for Europe: Public Administration Reform and European Union Accession in Central and Eastern Europe,* The World Bank, Washington.

Oliver, A. and Mossialos, E. (2005) "European Health Systems Reforms: Looking Backward to see Forward?", *Journal of Health Politics, Policy and Law* 30: 1–20.

Olsen, J., P. (2001) "The Many Faces of Europeanization" *ARENA Working Papers*, WP 01/2.

Orenstein, M. A. (1998) *How Politics and Institutions Affect Pension Reform in Three Post-communist Countries*, World Bank, Washington DC.

Orenstein, M. A. (2005) "The new pension reform as global policy", *Global Social Policy*, Vol. 5, no. 2, pp. 175-202.

Orloff, A., and Skocpol, T. (1984) "Why Not Equal Protection? Explaining the Politic of Public Social Spending in Britain, 1900–1911, and the United States, 1880s–1920", *American Sociological Review, No.* 49, 726–750.

Oswald, Sharon L., (2000) "Economic Transition in the Czech Republic: Attempts to Privatize the Health System", *Administration & Society*, Vol. 32, No. 3, July 2000 227-254, pp. 240-247, Sage Publications, Inc., http://aas.sagepub.com/cgi/reprint/32/3/227 (retrieved on August 28,2009).

Palm, W.; Nickless, N.; Lewalle, H.; Coheur, A. (2000) *Implications of recent jurisprudence on the co-ordination of health care protection systems*, report produced for the European Commission Directorate-General for Employment and Social Affairs, Brussels: Association Internationale de la Mutualité (AIM).

Peeters, M., (2005) "Free Movement of Medical Doctors: The new Directive 2005/36/EC on the Recognition of Professional Qualifications", *European Journal of Health Law,* No. 11, pp. 373-396

Proposal for a Directive Of The European Parliament And Of The Council on the application of patients' rights in cross-border healthcare, Brussels, 2.7.2008, presented by the Commission, p.5

Radaelli, C. M. (2000), "Whither Europeanization? Concept Stretching and Substantive Change", *European Integration online Papers*, Vol. 4, No. 8, http://eiop.or.at/eiop/pdf/2000-008.pdf (retrieved on May 22, 2009).

Radaelli, C. M. (2003a) "The Europeanization of Public Policy', in Radaelli C. and Featherstone, K. (eds.), *The Politics of Europeanization: Theory and Analysis,* Oxford: Oxford University Press, Featherstone and Radaelli, pp. 27-56.

Radaelli, C. M. (2003b) *The Open Method of Coordination: A new governance architecture for the European Union?*, Stockholm: Swedish Institute for European Policy Studies. available at www.sieps.su.se

Radaelli, C. M. and Pasquier, R. (2007) "Conceptual Issues", in Graziano, P. and Wink, M. P. (eds.), *Europeanization New Research Agendas,* New York: Palgrave Macmillan, pp. 35-45.

Risse, T., Cowles, M., G., and Caporaso, J. (2001) "Europeanization and Domestic Change: Introduction" in Cowles, M., G., Caporaso, J. and Thomas Risse (eds.) *Transforming Europe: Europeanization and Domestic Change*, Ithaca, NY: Cornell University Press, pp. 1-20.

Rittberger, B. (2003) *Endogenizing Institutional Change: Moving Beyond the Institutional "Holy Trinity."* Paper presented at the Second General Conference of the European Consortium for Political Research, Marburg, September 19–21.

Rokosova, M., Hava, P., Schreyögg J, Busse R. (2005) *Health care systems in transition: Czech Republic*, Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Rosenmöller, M., McKee, M., Baeten, R., (eds.) (2006) *Patient Mobility in the European Union: Learning From Experience*, European Observatory on Health Systems and Policies Series, Great Britain: The Cromwell Pres

Saltman, B., R., and Dubois, F.W.H. (2004) "The historical and social base of social health insurance systems", in Saltman, B., R., Buse, R., Figueras, J. (eds.), *Social Health Insurance Systems in Western*

Europe, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press, pp. 22-24.

Scarbrough, E. (2000) "West European welfare states: the old politics of retrenchment" *European Journal of Political Research,* Vol.38, No. 2, pp.225–259.

Scheffier, R. M. (1999) "Lessons Learned from the Reform of the Czech Health Care System" in M. Potucek (ed.), *Ceska spolecnost na konci tisicileti* [Czech Society at the End of the Millennium]. Vol. 2. Prague: Karolinum, p.4.

Schmidt, V., A. (1999) "The European Union And The Transformation Of National Patterns Of Governance", in Kohler-Koch, B. and Eising, R. (eds.), *The Transformation of Governance in the European Union*, London: Routledge, pp. 153-72

Sieveking, K, (2007) "ECJ Rulings on Health Care Services and Their Effects on the Freedom of Cross-Border Patient Mobility in the EU", *European Journal of Migration and Law*, No. 9, pp. 25–51.

Somers M., R. (1998) "We're No Angels: Realism, Rational Choice and Social Science, *The American Journal of Sociology,,* Vol. 104, No. 3, November 1998, pp. 722-784.

Sverdrup, U. (2007), "Chapter 15: Implementation", in Graziano, P. and Vink, M., P. (eds) *Europeanization New Research Agendas*, New York: Palgrave, pp.197-211

Tilly, C. (1988), "Future History", *Theory and Society*, Vol. 17, No. 15, Special Issue on Breaking Boundaries: Social Theory and the Sixties, September 1988, pp. 703-712.

Twaddle, A. (2002) *Health Care Reform Around the World*, Westport: Greenwood Publishing Group, p.127

Vink, M. (2002), "*What is Europeanization? And Other Questions on a New Research Agenda",* Paper for the Second YEN Research Meeting on Europeanisation, University of Bocconi, Milan, 22-23 November 2002

Walt, G. (1994) *Health Policy: An Introduction to Process and Power,* London: Zed Books

Warren, C.A.B. (1984) "Privatizing the public sector: Health care and "social control" institutions", *New Management*, Vol. 1, No. 3, pp. 29-33.

WHO Regional Office for Europe (2003) *Highlights on Health in the Candidate Countries for Accession to the European Union,* Grant Agreement SI2.108536 (99CVVF3-504).

WHOSIS-WHO Statistical Information System http://apps.who.int/whosis/data/Search.jsp (retrieved on May 10, 2009).

Zsuzsa Ferge, Z., and Juhasz, G., (2004) "Accession and Social Policy: The Case of Hungary", *Journal of European Social Policy*, Vol. 14, No. 3, pp. 233-251. http://esp.sagepub.com/cgi/content/abstract/14/3/233 (retrieved on August 12, 2009)

APPENDICES

Appendix A: Comparing The Health Care System Indicators Of Hungary And The Czech Republic With Eu Averages

Before assessing the health care indicators, it will be useful to cast a glance to the macroeconomic indicators of Hungary and the Czech Republic. These indicators will help us to comment the health care indicators. The main macroeconomic indicators of Hungary and the Czech Republic are shown in the below table.

Table A. 1. Main macroeconomic indicators of Hungary (in %)

	2000	2001	2002	2003	2004	2005	2006	2007
GDP Growth Rate	5.2	4.1	4.3	4.1	4.9	4.2	3.9	1.3
Consumer price index	9.8	9.2	5.3	4.7	6.8	3.6	3.9	8.0
Unemployment rate	6.4	5.7	5.8	5.9	6.1	7.2	7.5	7.4

Source: Dezseri: 2007 (years 2000-2005) ; Bilek et al.: 2008 (years 2006-2007)

Table A. 2. Main macroeconomic indicators of Czech Republic (in %)

	2003	2004	2005	2006	2007
GDP Growth Rate	3.6	4.4	6.3	6.5	6.2
Consumer price index	9.2	9.9	10.6	8.9	8.4
Unemployment rate	9.8	9.9	10.6	7.2	5.3

Source: http://www.tradingeconomics.com

The Czech economy has been led out of recession which came about during the first large privatization wave at the beginning of the 1990s. But after consecutive economic packages the economical structure of Czech Republic changes for the better. The convalescence can be seen from the table above. According to the table there is an increase in the GDP growth rate between 2003 and 2007. The unemployment rate of Czech Republic decreased from 9.8% to 5.3%. On the other hand the consumer price index, this is an important economic indicator that shows the economic welfare, does not have a sharp fluctuation.

The table below shows the general government expenditure on health as percentage of total government expenditure of the EU-15 countries. In this part of the thesis, the health indicators of Hungary and the Czech Republic is going to be compared with the average health indicators of the EU.

Table A. 3. General government expenditure on health as percentage of total government expenditure (EU-15 Countries)

	General Government Expenditure on Health as Percentage of Total Government Expenditure							
Location	1995	2000	2001	2002	2003	2004	2005	2006
Austria	12,5	14,7	14,9	15	15,1	14,7	15,6	15,5
Belgium	12,4	13,4	13,6	13,5	13,1	14,2	13,2	13,9
Denmark	11,2	12,6	12,9	13,2	14	14,2	14,8	15,6
Finland	9,2	10,2	10,7	11	11,1	11,3	11,6	12,1
France	14,2	14,6	14,8	14,9	16,2	16,4	16,6	16,7
Germany	15	18,2	17,4	17,5	17,5	17,3	17,5	17,6
Greece	9,8	10,1	11,8	11,7	11,9	10,9	11,5	11,5
Ireland	11,7	14,7	15,4	16,1	16,8	17,3	19,2	17,3
Italy	9,8	12,7	12,8	13,1	12,9	13,8	14,1	14,2
Luxembourg	13	13,9	14,7	14,8	16,2	17,3	16,5	16,8

Netherlands	10,6	11,4	11,5	12	12,4	12,6	13,2	16,4
Portugal	12,9	14,9	14,2	14,7	15,6	15,4	15,5	15,5
Spain	12,1	13,2	13,4	13,3	14,3	14,7	15,3	15,3
Sweden	10,4	12,4	13,2	13,5	13,7	13,6	13,6	13,4
United Kingdom	13	14,8	15,3	15,2	15,5	15,9	16	16,5

Source: WHOSIS-WHO Statistical Information System

As it can be mentioned in the above table the general government expenditure on health as percentage of total government expenditure for nearly all of the EU-15 countries has an increasing trend between the years 1995 and 2006. At the year 2006 the general government expenditure on health as a percentage of total government expenditure for EU-15 countries are fluctuating between %12.1 and %17.6. The health expenditure as percentage of total government expenditure of Hungary is %10.4 in the year 2006. This percentage is below the EU-15 countries percentages. When we compare this indicator for the Czech Republic we can clearly see that the general government expenditure on health as percentage of total government expenditure is %13.6. This is above Finland's and Sweden's indicator. The table below is showing the general government expenditure on health as percentage of total government expenditure for Hungary and the Czech Republic.

Table A. 4. General government expenditure on health as percentage of total government expenditure (Hungary and The Czech Republic)

	General Government Expenditure on Health as Percentage of Total Government Expenditure							
Location	1995	2000	2001	2002	2003	2004	2005	2006
Czech	11,7	14,1	13,5	13,8	14,1	14,2	14,1	13,6

Republic								
Hungary	11,3	10,5	10,4	10,4	12,0	11,7	11,1	10,4

Source: WHOSIS-WHO Statistical Information System

When comparing the health indicators it would be useful to compare the out-of-pocket expenditure as percentage of private expenditure on health. The first table below shows the out-of-pocket expenditure as percentage of private expenditure on health for Hungary and the Czech Republic and the second table below shows the same indicator for EU-15 countries.

Table A. 5. Out-of-Pocket expenditure as percentage of private expenditure on health (Hungary and the Czech Republic)

Location	Out-of-pocket expenditure as percentage of private expenditure on health							
	1995	2000	2001	2002	2003	2004	2005	2006
Czech Republic	100,0	100,0	100,0	100,0	97,7	95,4	95,3	95,5
Hungary	100,0	89,8	89,3	88,2	83,9	81,3	86,8	86,8

Source: WHOSIS-WHO Statistical Information System

According to the above table it could be said that, both for Hungary and the Czech Republic the out-of-pocket expenditures percentage per private expenditure on health is decreasing from 1995 to 2006. Private expenditure on health is made of %100 percent of out-of-pocket expenditures both for the Czech Republic and Hungary in 1995. But if we look at the percentage of out-of-pocket expenditure in 2006 it is %95.5 for the Czech Republic and %86.8 for Hungary. For comparing the indicators with the EU-15 countries it would be useful to analyze the below table.

Table A. 6. Out-of-Pocket expenditure as percentage of private expenditure on health (EU-15 Countries)

Location	Out-of-pocket expenditure as percentage of private expenditure on health							
	1995	2000	2001	2002	2003	2004	2005	2006
Austria	58,7	69,5	70,0	69,3	69,4	67,9	67,4	72,2
Belgium	86.8	84,7	84,7	84,9	79,7	78,4	78,7	78,7
Denmark	93.3	91,0	92,0	92,8	90,7	90,5	90,7	90,1
Finland	83.9	82,0	81,8	81,6	81,3	80,3	80,0	79,9
France	37,4	34,4	34,7	34,2	35,6	34,9	33,2	33,2
Germany	52,9	55,2	55,7	55,1	55,2	57,3	56,8	56,7
Greece	67,8	66,8	66,9	68,1	66,7	66,6	62,0	62,5
Ireland	47,9	41,0	46,3	52,0	58,8	63,4	59,3	57,2
Italy	91,1	89,1	87,4	87,8	88,4	87,0	86,6	86,2
Luxembourg	81,3	65,2	65,2	70,6	71,2	70,2	70,5	70,5
Netherlands	33,3	24,3	23,4	21,4	23,2	22,2	21,9	33,0
Portugal	59,9	88,0	81,3	80,5	78,9	79,3	79,8	80,2
Spain	84,6	83,1	83,1	82,6	73,7	73,1	73,1	76,4
Sweden	99,9	91,1	87,2	86,3	87,6	87,4	88,5	87,9
United Kingdom	84,6	69,5	78,3	80,3	91,0	91,8	92,1	92,2

Source: WHOSIS-WHO Statistical Information System

The average of the out-of-pocket expenditures as percentage of private expenditure on health of the EU-15 countries for the year 1995 is %70.9. When this number is compared with Hungary and the Czech Republic, it can be clearly said that the average of Hungary and the Czech Republic is very high in accordance with EU-15 countries. The average of the out-of-pocket expenditures as percentage of private expenditure on health in 2006 for the EU-15 countries is %70.5. For Hungary this indicator is %86.8 and for the Czech Republic it is %95.5.

It can clearly said that although the transition process of the health care system of Hungary and the Czech Republic, the indicators are not at the same level of the EU-15 countries average.

Another core health indicator that should be compared is the per capita total expenditure on health. Total health expenditure per capita is the per capita amount of the sum Public Health Expenditure and Private Expenditure on Health. The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. So, per capita total expenditure on health will be analyzed at average exchange rate of US Dollars. The below table shows the per capita total expenditure on health at average exchange rate of US Dollars for the EU-15 countries.

Table A. 7. Per capita total expenditure on health at average exchange rate US Dollar (EU-15 Countries)

	Per capita total expenditure on health at average exchange rate (US$)				
Location	1995	2000	2002	2004	2006
Austria	2917	2380	2589	3683	3864
Belgium	2298	2061	2315	3322	3565
Denmark	2827	2478	2836	4246	4828
Finland	1906	1549	1831	2649	2994
France	2677	2149	2443	3723	4056
Germany	3118	2382	2603	3499	3669
Greece	1064	1245	1507	2301	2733
Ireland	1249	1598	2230	3397	3888
Italy	1440	1547	1768	2604	2845
Luxembourg	2786	2720	3441	6080	6610
Netherlands	2257	1924	2405	3385	3784
Portugal	1002	970	1107	1689	1830

Spain	1127	1036	1207	1962	2263
Sweden	2290	2280	2493	3666	3870
United Kingdom	1370	1782	2028	2880	3361

Source: WHOSIS-WHO Statistical Information System

The average of the per capita total expenditure on health is 2020.18 USD in 1995, 3510.37 USD in 2006 and respectively 1881.31 USD, 2175.31USD, 3193.12 USD in years 2000, 2002 and 2004. After a sharp decrease from 1995 to 2000, it can be said that there is a stable increase from 2000 to 2006. The highest per capita total expenditure on health in 2006 is 6610 USD. This indicator is Luxembourg's. The lowest one is 1830 USD and this is Portugal's health expenditure. If we compare this core health indicator with Hungary and the Czech Republic, the result is bleak. When the minimum per capita total expenditure on health, in 2006, is 1830 USD for the countries above Hungary's per capita total expenditure on health is 853 USD and the Czech Republic's is 943 USD. These numbers are desperately below the average of the EU countries. Although there is a increase from the year 1995 to 2006 for both Hungary and the Czech Republic the indicator is not at the same level of the EU countries. The march of the indicator for Hungary and the Czech Republic can be followed from the below table.

Table A. 8. Per capita total expenditure on health at average exchange rate US Dollar (Hungary and the Czech Republic)

Location	Per capita total expenditure on health at average exchange rate (US$)				
	1995	2000	2002	2004	2006
Czech Republic	374	361	523	771	943
Hungary	323	326	496	818	853

Source: WHOSIS-WHO Statistical Information System

After comparing the per capita total expenditure on health, it will be useful to compare the per capita government expenditure on health. The below tables show the per capita government expenditure on health at average exchange rate US Dollar for EU, Hungary and the Czech Republic.

Table A. 9. Per capita government expenditure on health at average exchange rate USD Dollar (Hungary and the Czech Republic)

Location	Per capita government expenditure on health at average exchange rate (US $)				
	1995	2000	2002	2004	2006
Czech Republic	340,0	326,0	473,0	687,0	829,0
Hungary	271,0	231,0	348,0	577,0	604,0

Source: WHOSIS-WHO Statistical Information System

As it is expected the per capita government expenditure on health in US Dollars both for Hungary and the Czech Republic as nearly the same level of the per capita total expenditure on health. Another expectation for this indicator is that; because the per capita total expenditure on health is below the average of EU for Hungary and the Czech Republic, this indicator for Hungary and the Czech Republic will be lower than the EU average. The table below will help to analyze this expectation.

Table A. 10. Per capita government expenditure on health at average exchange rate USD Dollar (EU-15 Countries)

Location	Per capita government expenditure on health at average exchange rate (US $)				
	1995	2000	2002	2004	2006
Austria	2085,0	1806,0	1953,0	2783,0	2975,0
Belgium	1815,0	1479,0	1648,0	2400,0	2536,0
Denmark	2333,0	2043,0	2352,0	3547,0	4054,0
Finland	1440,0	1164,0	1397,0	2045,0	2350,0
France	2104,0	1683,0	1920,0	2956,0	3233,0
Germany	2543,0	1897,0	2062,0	2690,0	2809,0
Greece	554,0	550,0	709,0	1026,0	1160,0
Ireland	898,0	1175,0	1695,0	2669,0	3043,0
Italy	1019,0	1122,0	1317,0	1973,0	2194,0
Luxembourg	2075,0	2428,0	3109,0	5510,0	5991,0
Netherlands	1603,0	1214,0	1502,0	2183,0	3097,0
Portugal	644,0	704,0	800,0	1217,0	1315,0
Spain	814,0	742,0	861,0	1391,0	1641,0
Sweden	1984,0	1936,0	2132,0	3000,0	3143,0
United Kingdom	1149,0	1441,0	1691,0	2485,0	2939,0

Source: WHOSIS-WHO Statistical Information System

As it is expected the per capita government expenditures on health of Hungary and the Czech Republic is lower than the average of EU countries for all of the base years. The average of EU Countries is 2832 USD in 2006 and for Hungary it is 604 USD and 829 USD for the Czech Republic. Both of the numbers are below the average of EU.

Indicators that will be analyzed next are; general government expenditure on health as percentage of total expenditure on health and private expenditure on health as a percentage of total expenditure of health. Logically, if a countries government expenditure on health has a

higher share in total expenditure, it is expected that the share of the private expenditures are less. The tables that are showing the indicators are below.

Table A. 11. General government expenditure on health as percentage of total expenditure on health

	General government expenditure on health as percentage of total expenditure on health							
Location	1995	2000	2001	2002	2003	2004	2005	2006
Austria	71,5	75,9	75,7	75,4	75,3	75,6	75,7	77,0
Belgium	79,0	71,8	71,7	71,2	70,6	72,3	71,4	71,1
Denmark	82,5	82,4	82,7	82,9	83,8	83,5	83,6	84,0
Finland	75,6	75,1	75,9	76,3	76,2	77,2	77,8	78,5
France	78,6	78,3	78,3	78,6	79,4	79,4	79,9	79,7
Germany	81,6	79,7	79,3	79,2	78,7	76,9	76,9	76,6
Greece	52,0	44,2	47,4	47,0	46,4	44,6	42,8	42,5
Ireland	71,9	73,5	74,1	76,0	77,2	78,6	79,5	78,3
Italy	70,8	72,5	74,6	74,5	74,7	75,8	76,6	77,1
Luxembourg	92,4	89,3	87,9	90,3	90,3	90,6	90,7	90,6
Netherlands	71,0	63,1	62,8	62,5	65,4	64,5	64,9	81,8
Portugal	64,3	72,5	71,5	72,2	73,3	72,0	72,3	71,8
Spain	72,2	71,6	71,2	71,3	70,3	70,9	71,4	72,5
Sweden	86,6	84,9	85,5	85,5	85,7	81,8	81,7	81,2
United Kingdom	83,9	80,9	83,0	83,4	85,6	86,3	87,1	87,4
Czech Republic	*90,9*	*90,3*	*89,8*	*90,5*	*89,8*	*89,2*	*88,6*	*87,9*
Hungary	*84,0*	*70,7*	*69,0*	*70,2*	*71,3*	*70,5*	*70,8*	*70,8*

Source: WHOSIS-WHO Statistical Information System

According to above table the EU average for the general government expenditure on health as percentage of total expenditures on health is respectively %75.6, %74.4, %75.1, %75.5, %75.3, %75.5 and %76.7 for

the years 1995, 2000, 2001, 2002, 2003, 2004, 2005 and 2006. When these are compared with the Czech Republic, the Czech's percentage is higher than the averages of EU among all years. So it can be said that the government compensate of the health expenditure in the Czech Republic more than the EU countries. The same result is seen for Hungary. Hungarian government compensates most of the health expenditure. In parallel, it is expected that the private health expenditure has a small share in total health expenditure in EU, Hungary and the Czech Republic. The table below shows the private expenditure on health as percentage of total expenditures on health.

Table A. 12. Private expenditure on health as percentage of total expenditure on health

	Private expenditure on health as persentage of total expenduture on health							
Location	1995	2000	2001	2002	2003	2004	2005	2006
Austria	28,5	24,1	24,3	24,6	24,7	24,4	24,3	23,0
Belgium	21,0	28,2	28,3	28,8	29,4	27,7	28,6	28,9
Denmark	17,5	17,6	17,3	17,1	16,2	16,5	16,4	16,0
Finland	24,4	24,9	24,1	23,7	23,8	22,8	22,2	21,5
France	21,4	21,7	21,7	21,4	20,6	20,6	20,1	20,3
Germany	18,4	20,3	20,7	20,8	21,3	23,1	23,1	23,4
Greece	48,0	55,8	52,6	53,0	53,6	55,4	57,2	57,5
Ireland	28,1	26,5	25,9	24,0	22,8	21,4	20,5	21,7
Italy	29,2	27,5	25,4	25,5	25,3	24,2	23,4	22,9
Luxembourg	7,6	10,7	9,9	9,7	9,7	9,4	9,3	9,4
Netherlands	29,0	36,9	37,2	37,5	34,6	35,5	35,1	18,2
Portugal	35,7	27,5	28,5	27,8	26,7	28,0	27,7	28,2
Spain	27,8	28,4	28,8	28,7	29,7	29,1	28,6	27,5
Sweden	13,4	15,1	19,0	18,7	18,2	18,2	18,3	18,8
United Kingdom	16,1	19,1	17,0	16,6	14,4	13,7	12,9	12,6
Czech Republic	*9,1*	*9,7*	*10,2*	*9,5*	*10,2*	*10,8*	*11,4*	*12,1*

Hungary	*16,0*	*29,3*	*31,0*	*29,8*	*28,7*	*29,5*	*29,2*	*29,2*

Source: WHOSIS-WHO Statistical Information System

The average of private health expenditure of EU countries is respectively %24.4, %25.6, %25.4, %25.2, %24.7, %24.5 and %23.3 for the years 1995, 2000, 2001, 2002, 2003, 2004, 2005 and 2006. As expected the private expenditures have less share than government expenditures in total health expenditures all for EU, Hungary and the Czech Republic.

An important core health indicator is; total expenditure on health as percentage of GDP. The table below shows the total expenditure on health as percentage of GDP.

Table A. 13. Total expenditure on health as percentage of GDP

Location	Total expenditure on health as percentage of GDP							
	1995	2000	2001	2002	2003	2004	2005	2006
Austria	9,8	10	10,1	10	10,2	10,3	10,2	9,9
Belgium	8,2	9,1	9,3	9,5	9,5	9,7	9,6	9,5
Denmark	8,1	8,3	8,6	8,8	9,3	9,4	9,4	9,5
Finland	7,5	6,6	6,7	7	7,3	7,4	7,5	7,6
France	9,9	9,6	9,7	10	10,9	11	11,2	11,1
Germany	10,1	10,3	10,4	10,6	10,8	10,6	10,7	10,4
Greece	7,5	9,3	9,8	9,7	10	9,6	10,1	9,9
Ireland	6,7	6,3	6,9	7,1	7,3	7,5	8,2	7,5
Italy	7,3	8,1	8,2	8,3	8,3	8,7	8,9	9
Luxembourg	5,6	5,8	6,4	6,8	7,5	8,1	7,7	7,2
Netherlands	8,3	8	8,3	8,9	8,9	9	9,2	9,3
Portugal	8,7	8,8	8,8	9	9,7	10	10,2	10
Spain	7,4	7,2	7,2	7,3	7,8	8,1	8,2	8,1

Sweden	8	8,2	8,6	9	9,1	9,2	9,2	8,9
United Kingdom	6,9	7,2	7,5	7,6	7,7	8	8,2	8,4
Czech Republic	*7*	*6,5*	*6,7*	*7,1*	*7,4*	*7,2*	*7,1*	*6,8*
Hungary	*7,3*	*6,9*	*7,2*	*7,6*	*8,3*	*8,1*	*7,8*	*7,6*

Source: WHOSIS-WHO Statistical Information System,

Total expenditure on health as a percentage of gross domestic product is the total of government, third party (such as employer and insurance), and out-of-pocket individual amounts spent for health care in each country, as a percent of the country's. In 2006 the indicator belong to EU fluctuates between 7.2 and 11.1. Luxembourg has the smallest total expenditure on health as a percentage of GDP in 2006. If we compare the Czech Republic’s indicator in 2006 it is seen that it is lower than the smallest one of the EU. On the other hand Hungary’s total expenditure of health as a percentage of GDP is higher than the smallest one of the EU, it is 7.6.

The Czech Republic’s total expenditure on health as a percentage of GDP fluctuates between 7 and 6.8. The indicator increased between the years 2002 and 2005 when compared with the year 1995. But in 2006 the indicator decreased to the 7.1 level. Hungary’s total expenditure on health has an ascendant trend between the years 1995 and 2006 in general. The indicator reached its top level in the year 2003. After then it decreased a little but in 2006 it is still higher than the beginning year 1995.

Social security expenditure on health as a percentage of general government expenditure on health is another core indicator used to

compare the health care system. Social security expenditure on health includes outlays for purchases of health goods and services by schemes that are mandatory and controlled by government. Such social security schemes that apply only to a selected group of the population, such as public sector employees only, are also included (www.globalhealthfacts.org). The table below shows the social security expenditure on health as a percentage of general government expenditure on health for EU, Hungary and the Czech Republic.

Table A. 14. Social security expenditure on health as a percentage of general government expenditure

	Social security expenditure on health as percentage of general government expenditure on health				
Location	1995	2000	2002	2004	2006
Austria	56,5	60,2	59,5	61	61
Belgium	75,4	79,9	82,4	93,8	93,6
Denmark	0	0	0	0	0
Finland	17,7	20,4	21,1	21,8	20,3
France	89,9	89,5	95,4	93,8	93,6
Germany	82,5	87,3	87,3	87,1	87,5
Greece	22,7	31,9	49,9	54,1	53
Ireland	1,3	1,2	0,9	0,8	0,9
Italy	0,4	0,1	0,1	0,1	0,2
Luxembourg	83,4	82,6	85,9	80,8	78,6
Netherlands	93,6	93,9	93,8	93,9	95,1
Portugal	6,2	1,3	1,3	1,1	1,1
Spain	23,6	9,6	7,4	7,2	7,6
Sweden	0	0	0	0	0
United Kingdom	0	0	0	0	0
Czech Republic	*83,8*	*89,5*	*89,9*	*89,2*	*89,4*
Hungary	*80*	*83,9*	*81,3*	*85*	*90,3*

Source: WHOSIS-WHO Statistical Information System

According to table France, Germany, Luxembourg and Netherlands have the highest percentage of social security expenditure. The percentage of the social security expenditure on health for the Czech Republic and Hungary are nearly the same level with France, Germany, Luxembourg and Netherlands.

Life expectancy at birth is an important indicator that should be compared. The table below shows the life expectancy birth for EU countries, Hungary and the Czech Republic.

Table A. 15. Life expectancy at birth

	Life expectancy at birth (years) female			Life expectancy at birth (years) male			Life expectancy at birth (years) both sexes		
Location	1990	2000	2006	1990	2000	2006	1990	2000	2006
Austria	79,0	81,0	83,0	72,0	75,0	77,0	76,0	78,0	80,0
Belgium	79,0	81,0	82,0	73,0	75,0	77,0	76,0	78,0	79,0
Denmark	78,0	79,0	81,0	72,0	75,0	76,0	75,0	77,0	79,0
Finland	79,0	81,0	83,0	71,0	74,0	76,0	75,0	78,0	79,0
France	81,0	83,0	84,0	73,0	75,0	77,0	77,0	79,0	81,0
Germany	78,0	81,0	82,0	72,0	75,0	77,0	75,0	78,0	80,0
Greece	79,0	81,0	82,0	75,0	76,0	77,0	77,0	78,0	80,0
Ireland	78,0	79,0	82,0	72,0	74,0	77,0	75,0	76,0	80,0
Italy	80,0	82,0	84,0	74,0	76,0	78,0	77,0	79,0	81,0
Luxembourg	79,0	81,0	83,0	72,0	75,0	77,0	75,0	78,0	80,0
Netherlands	80,0	81,0	82,0	74,0	76,0	78,0	77,0	78,0	80,0
Portugal	77,0	80,0	82,0	71,0	73,0	75,0	74,0	77,0	79,0
Spain	80,0	83,0	84,0	73,0	76,0	78,0	77,0	79,0	81,0
Sweden	72,0	82,0	83,0	68,0	77,0	79,0	70,0	80,0	81,0
United Kingdom	78,0	80,0	81,0	73,0	75,0	77,0	76,0	78,0	79,0
EU Average	78,5	81,0	82,5	72,3	75,1	77,1	75,5	78,1	79,9
Czech Republic	*75*	*79*	*80*	*68*	*72*	*73*	*71,00*	*75,00*	*77,00*

Hungary	*74*	*76*	*78*	*65*	*68*	*69*	*69,00*	*72,00*	*73,00*

Source: WHOSIS-WHO Statistical Information System

The life expectancy at birth for the female citizens in the EU has 82.5 years average in 2006. The life expectancy at birth of the female citizens is 80 years in the Czech Republic and 78 years in Hungary. This numbers are nearly at the same level of the EU citizens' average. When we glance at the male citizens' life expectancy at birth, EU citizens' average is 77.1 years while Czech's male citizens' life expectancy at birth is 73 and the Hungarian's is 69 years. These numbers are lower than the EU's average. When we compare the female and male citizens' life expectancies; females' life expectancy at birth is closer than the EU's average when compared with males.

Between the years 1990 and 2006 both for the Czech Republic and Hungary the life expectancy at birth is increasing per years. This can be commented as the health system transition of Hungary and the Czech Republic has a positive trend. Although the indicator is not at the same level of the EU, the health care services are adequate in the Czech Republic and Hungary because of the life expectancy at birth has an ascendant trend.

The adult mortality rate and infant mortality rate are important indicators that would be considered while comparing the health care systems. The table below shows the adult mortality rate and infant mortality rate for EU, Hungary and the Czech Republic.

Table A. 16. The adult and infant mortality rate

Location	Adult mortality rate (probability of dying between 15 to 60 years per 1000 population) both sexes			Infant mortality rate (per 1000 live births) both sexes		
	1990	2000	2006	1990	2000	2006
Austria	114,0	95,0	79,0	8,00	5,00	4,00
Belgium	107,0	100,0	86,0	8,00	5,00	4,00
Denmark	126,0	100,0	88,0	7,00	5,00	3,00
Finland	128,0	104,0	96,0	6,00	4,00	3,00
France	15,0	100,0	91,0	7,00	4,00	4,00
Germany	118,0	94,0	81,0	7,00	4,00	4,00
Greece	86,0	82,0	76,0	9,00	6,00	4,00
Ireland	108,0	96,0	72,0	8,00	6,00	4,00
Italy	95,0	76,0	64,0	8,00	5,00	3,00
Luxembourg	121,0	95,0	83,0	8,00	4,00	3,00
Netherlands	92,0	84,0	70,0	7,00	5,00	4,00
Portugal	127,0	111,0	93,0	11,00	6,00	3,00
Spain	103,0	86,0	75,0	7,00	4,00	4,00
Sweden	105,0	72,0	64,0	6,00	3,00	3,00
United Kingdom	104,0	88,0	80,0	8,00	6,00	5,00
EU Average	103,3	92,2	79,9	7,7	4,8	3,7
Czech Republic	163,0	124,0	108,0	11,0	4,0	3,0
Hungary	219,0	193,0	177,0	15,0	9,0	6,0

Source: WHOSIS-WHO Statistical Information System

The adult mortality rate for both sexes of EU has a decreasing trend from the year 1990 to 2006. The same situation, the decaying trend, is valid to the Czech Republic and Hungary. This decaying trend bode

well but when compared with EU average the Czech's and Hungary's adult mortality rate for both sexes is dramatically above the EU's average. While EU average of the adult mortality rate for both sexes is 79.9 in 2006, this rate is 108 for the Czech Republic and 177 for Hungary.

EU average of the infant mortality rate for both sexes has a decaying trend between the years 1990 and 2006. When the infant mortality rate for both sexes is 7.7 in 1990, it is 3.7 in 2006. The Czech Republic's infant mortality rate for both sexes decreased from 11 to 3 between the years 1990 and 2006. And the rate of the year 2006 is below the EU average. The Hungary's infant mortality rate for both sexes has a decaying trend as the Czech Republic but although this decaying trend the rate 6 is still above the EU average.